A Clinical Lecture ON TERTIARY SYPHILIS OF THE SOFT PALATE AND PHARYNX.

Delivered at University College Hospital, Feb. 24th, 1876,

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GENTLEMEN,—There have been recently in hospital some cases of late syphilis of the palate and pharynx which exemplify the various ways in which that disease manifests itself in that region; and as I have been fortunate enough to obtain for you to-day several examples of these affections, it will, I think, be profitable to consider the morbid conditions more systematically than is possible when watching the progress of single cases in the wards or out-patients' room.

In passing, let me remind you of a peculiarity in the course of syphilis concerning the pharynx—namely, the rarity with which the pharynx proper is attacked in the early periods of syphilis. As you know, the anterior surface of the velum palati, the pillars, and the tonsils are constantly the seat of erosion, mucous patches, &c., while the eruptions are present on the skin. The larynx likewise is commonly affected in early syphilis. The pharynx nearly always escapes. The reason of this is not obvious, for there is no natural incapacity in the part; mucous patches and erythema are occasionally seen on the posterior wall of the pharynx. In searching for cases of tertiary pharyngeal disease, I came upon one case where a mucous patch was recorded to have been developed in the posterior wall of the pharynx during the early eruptive period. This is, however, the only one I recollect to have seen. Besides mucous patches in adults, in inherited syphilis, when there is coryza of the Schneiderian membrane, the pharynx is frequently reddened. On the other hand, in the later periods of syphilis, when for the great majority of persons the disease is extinct, the pharynx is a chosen site for tertiary affections, and the ramifications into neighbouring structures are often widely spread.

With regard to the time after infection that tertiaries appear in the pharynx, reference to my notes shows that a shorter interval is customary than is generally laid down in text-books. It is often difficult to obtain precise data on which one may rely for calculating the age of syphilis. In a remarkable case of aphasia from syphilitic disease of the brain, whom many of you may recollect to have seen frequently during 1874–5, the patient's pharynx was attacked four years after infection. Besides seven patients who are here to-day for your inspection, I have also collected nine cases from my female case-book for 1868 at the Lock Hospital, in which the date of their infection and that of the beginning of their throat disease are clearly made out. Of the seven patients, in three the date of infection is probably long anterior to their throat disease; two are married women, and their syphilitic histories have for a chief symptom a long series of miscarriages and dead children; the third is a man, but though uncertain how long, he has probably been infected more than five years. In the remaining four, one was infected five years ago, and has had his throat fourteen months affected; in another a circumscribed gumma began two years after infection. The remaining two patients are young, eighteen and ten years of age respectively, and their syphilis dates from infancy, being probably inherited. They are quite unaware when their throats were first affected, though certainly it happened several years ago. In the nine cases from the note-book—in one the disease began three years after infection, in four between four and seven years, in two more than seven years, and in the remaining two more than ten years elapsed between infection and the outbreak of tertiary in the throat. From these data it would seem that four or five years is the commonest period for syphilitic persons to become liable to gummous disease of the palate and pharynx, though it is not infrequent for their disease to begin sooner than that. Mark another point also in these cases. The early skin eruptions were ill-marked and transient, so fugitive in some that the patients had not noticed them at all. The man with a gap in the velum is quite unaware that he ever had a rash. All he recollects is a comparatively recent tertiary ulcer of the skin. I draw your attention to this character, because I believe it to be a frequent one in those who have tertiary syphilis of any kind, and probably has some influence in causing the tertiary proclivity.

There are two forms of gummy disease of the palate and pharynx: the *circumscribed* and the *diffuse*, or infiltrating. Their anatomical seat is the mucous membrane, the submucous or muscular layers. These different localities of origin cause some diversity in the symptoms and effects; thus they have a practical interest. The circumscribed and infiltrating varieties may be present simultaneously, though often only one is developed. This child, whose gumma of the forehead was so conspicuous two weeks ago, is an example of the diffused form. Her palate is seamed in all directions with the scars of an infiltrating gumma of the mucous membrane, which, not having penetrated the muscular tissue, has not greatly interfered with the function of the part. This man, from ward No. 10, has a round hole in his palate, but now the edges are healed, the remainder of the palate being unaltered. He is an example of the circumscribed gumma. This woman, whose long history of miscarriages and dead children we extracted from her some days ago, has well-marked infiltrating gumma of the posterior wall of the pharynx and extensive implication of the bones of the nose and base of the skull.

The circumscribed gumma is the most common form, both in the velum and in the pharynx proper. It is usually single, though not invariably so. Owing to the insidious progress, it rarely attracts attention until it breaks by ulceration. If, however, a gumma is detected at an early stage, it presents a small, clearly circumscribed, solid mass, often almost globular in shape. In the velum, most frequent at the mesial line, near the hard palate, rarely at the sides, though I have seen it in the anterior pillars, and even in the uvula. In the pharynx there appears no predilection for the mesial line; there they form indifferently on any part. Beginning most commonly in the submucous or muscular layer, the great majority speedily spread to the other structures, and grow sometimes to a considerable size before they soften and break through the surface. Seldom larger than a cherry, they are recorded to have grown as large as a hen's egg. In such cases they have seriously impeded deglutition and respiration by their mere bulk. Fournier* relates a case where a patient, having long had a "bad" throat, became at last quite unable to swallow, and breathed but with great difficulty. Nothing could be seen, but on searching the neck with the finger opposite the thyroid cartilage a swelling, apparently as large as a quarter of a lemon, could be detected. Presuming this to be syphilitic from the patient having had syphilis previously, he administered iodide of potash. In a few days the swelling was gone, and the patient could eat and breathe with perfect ease.

If untreated, sooner or later, generally in a few weeks, the tumour softens, and its liquid part escapes in the form of glairy viscid fluid, which is soon changed to viscid pus. Thus an ulcer is formed of circular or nearly circular shape, the surface irregular, hollowed; through its covering of adhesive pus project shreds of gummous tissue not yet detached, and irregular granulations. The edges of the ulcer are characteristic; they are thickened, raised, and reddish, forming often a kind of frame to the sore. Thus a large gap in the velum or a pit in the pharynx is produced, which is commonly increased by further conversion of the natural tissue into gummous tissue, and destruction by necrosis or phagedænic ulceration. But this is not invariable; instances are not rare in which the velum is perforated by a round hole, supple, and contracting or expanding readily by muscular action. If the gap in the velum is large, fluids, especially thin ones, escape into the posterior nares, and the voice assumes more or less of a nasal twang. But when the hole is small it often produces no perceptible effect on arti-

* Doyen's Annales de Dermatologie et de Syphilis. No. 6, 1873-4.

culation, and the patient learns to compel the food to pass completely into the gullet. Less inconvenience than even this results from a circumscribed gumma in the pharynx, which, when healed, leaves only a depressed scar. The serious deformities of the palate or pharynx are produced by the infiltrating form which I shall presently describe.

When the gumma is developed on the posterior surface of the velum, or summit of the pharynx, it is rarely detected in an early stage, or until ulceration is far advanced. The symptoms that lead to suspicion of it are usually present to some degree: they are, dryness and discomfort of the pharynx, a frequent desire to clear the throat of a viscid mucus, which is less readily accomplished than usual, pain in swallowing, a humming in the ears when the gumma is situated near the Eustachian tubes, obstinate coryza, and, after ulceration has begun, pus and streaks of blood in the discharge from the nose. These symptoms get worse rather than better with lapse of time. But it often happens that considerable injury is caused before the nature of the disease is discovered. There was an interesting example of this kind last year in Ward 3, under the care of Dr. Wilson Fox, with whom I saw the patient on several occasions. The patient, giving no history of previous syphilis, complained of great pain in swallowing, dryness of the throat, and general malaise. Nothing could be seen in the throat except pallor of the velum, nor could anything be detected by the finger. While we were uncertain of the nature of her ailment, luckily for our diagnosis an iritis appeared in the left eye, which gave a clue to the origin of the throat affection. That, with the iritis, speedily improved when mercury was given, though not before the gumma became evident in the palate, and, breaking, left a permanent gap. I need not remind you that in searching for these gummata you should use the rhinoscopic mirror, and you may gain in that way ocular demonstration of the cause of the symptoms. But you will meet with patients whose fauces are too irritable to allow the velum to be lifted while the mirror is introduced. When this is so, if you take a broad bent spatula or spoon to draw the velum well forward, and while the head is opposite a good light, the greater part of the back of the palate and pharynx can be seen before reflex movement is roused. The palate appears to bear forcible displacement with a broad blunt surface more patiently than the gentle tickling of a small hook or the pinch of a forceps.

The *diffused* or infiltrating form develops in two varieties—that which limits itself mainly to the mucous membrane, and the severer variety which penetrates the submucous and muscular layers. The first leaves widespread seams and branching scars, the site of former creeping ulcers; but, the deeper layers having escaped, the organ retains its mobility, and apparently has undergone no detriment of function. The penetrating variety converts all it reaches into a tough, brawny, resisting tissue, and its progress is difficult to arrest before the whole velum and pharynx have been essentially altered in structure. At the outset the velum and pillars are much thickened, partly by the new growth, partly by œdema, which greatly hamper the action of the muscles. Soon the infiltration reaches the posterior wall of the pharynx, which, rendered thick and rigid, projects forward towards the velum, and greatly diminishes the cavity of the pharynx. A considerable surface is invaded before ulceration begins, but sooner or later the surface breaks, often at several centres, and a group of indolent uneven sores are formed, healing here and spreading there, and covered with sticky muco-pus or diphtheritic exudation. The healing process is also peculiar. The rigid infiltration, so widely and deeply penetrating, is slowly transformed into a tough, highly contractile fibrous tissue, which replaces the normal tissue; its only covering being a brittle epithelium, that is readily chafed away into shallow indolent sores. The consequences of this slow conversion of the natural tissue into dense tough fibrous cicatrix are pain, deformity, and more or less loss of function to the organ.

Severe pain is seldom felt before ulceration with the isolated gumma; here, on the contrary, pain begins very early, varying in amount with the situation of the morbid process. When the parts are at rest there is little pain, but speaking more than a few words brings a sense of fatigue from the impediment or muscular contraction. The voice is thick and husky at first, becoming, when contraction is advanced, hissing or hoarse, like a drake's; and, owing to the difficulty of swallowing, the patient is continually hawking and spitting out a thick glue-like mucus. Swallowing inflicts most severe pain; solids after a time cannot be swallowed at all, and then liquids with great difficulty.

But these calamities are not the worst that may befall the miserable patient. The infiltrating new growth may spread to the posterior nares, destroying the mucous and periosteal lining of the delicate bones, causing either necrosis of large pieces or destroying them by syphilitic osteitis. In this way, the bones of the nose, of the palate, of the sphenoid, of the basilar part of the occipital bone, the bodies of the upper cervical vertebræ, may be cleared away. Thus the brain or the spinal cord may be seriously and fatally affected. Sometimes the infiltration and consequent phagedæna reach a large bloodvessel and occasion sudden dangerous hæmorrhage. There is another effect produced by the contracting scars: the remnant of the velum becomes adherent to the roof of the pharynx. Usually there is left a gap in the centre, large enough for the forefinger to enter, by which communication between the nose and the pharynx is still possible. But sometimes this aperture is very small, or even entirely closed, when of course air can reach the lungs through the mouth alone. At other times the greatest deformity is in the fauces; the isthmus is replaced by a gristly ring much narrower than the natural mobile yielding sphincter, and which draws up and holds the root of the tongue and epiglottis, or the remains of that structure, in an almost immovable position. It is difficult to exaggerate the constant suffering this entails.

A few words on the treatment of these cases. This resolves itself into curing the general cachexia, and allaying the local suffering. The iodides of potash, soda, or ammonia are the chief resources. In most cases you have merely to begin with moderate doses of iodide of potash, and gradually increase them by adding one-third to the dose every three days as long as the gummata are not absorbed, and the ulcers unhealed. As soon as they are healed the iodide may be lessened, and, after a few weeks, omitted for a time altogether. But, unfortunately, there are patients who cannot take iodide of potash in sufficient doses, or even at all, without being iodised. Most of these patients nevertheless can be brought to bear iodine if it be given in a way suited to them. Sometimes the iodide of soda is borne when the potash salt causes intolerable depression, and both are more efficacious when they are taken with carbonate of ammonia. Sarsaparilla also will afford tolerance for large doses. The time at which the medicine is taken is of importance. The stomach can bear a heavier dose when full of food than when fasting. Again, a large dose can often be borne at bedtime if drunk with effervescing water. Perhaps the effervescing carbonic acid soothes the stomach until the iodide is absorbed. When neither iodide of potash nor iodide of soda is tolerated, there is still the iodide of ammonia, which, being wholly volatile, probably undergoes complete decomposition, and affects the blood less injuriously than do the large quantities of fixed alkali which are combined in the other iodides. But this salt is very unstable, decomposing in even watery solutions, and still more readily in vegetable infusions. Hence, when given an excess of sesquicarbonate of ammonia must be added to the solution. With this precaution this iodide will sometimes succeed when the others have failed. As an antidote to syphilis it is, I believe, identical with them in its effect. The next drug in order is mercury. Indeed, though it is advisable to delay the administration of mercury until the iodides have driven away the gumma, healed the ulcers, and restored the patient's strength to some extent, mercury should always form a part of the course. When iodides cannot be borne, try mercury at once; and in these debilitated persons the least injurious way is by inunction. Every evening twenty grains of the strong mercury ointment should be rubbed into the skin. This may be done also while the iodide is continued. If given by the mouth, a suitable dose is three-quarters of a grain of the green iodide of mercury as a pill daily at breakfast-time; or one-sixteenth of a grain of cyanide or bichloride of mercury in a pill, with a sufficiency of sugar of milk, every four or six hours, is also an efficacious way of bringing the patient under the influence of the drug without distressing the stomach.

Indeed I have found that mercury, like some other medicines, is more effectual in small frequent doses than in large doses at long intervals. The disadvantage of frequent doses lies in this: the patient is apt to forget some of his pills when he has several to take in the course of the day. He can manage one night and morning, but the intervening doses are often omitted. When the patient has been fitted with the form of antidote, whether of iodine or mercury, which he can absorb, his recovery may be assisted or his suffering relieved by opium, also in small frequent doses, and strength be given by iron, quinine, or cod-liver oil. He will need suggestions for supplying himself with nourishing food that he can swallow; such must be chiefly strong soups thickened with arrowroot, milk similarly thickened, jellies with wine in them, and such easily-swallowed solids. That well-puffed article of food, revalenta arabica, prepared with milk, is an excellent kind of food for these patients. It is not a starch, but chiefly a very purely-prepared flour of lentils. Much alcohol is hurtful, by hindering the absorption of mercury or iodine. Then as to local remedies: caustics must be avoided, they cause pain when they reach the ulcers, and don't arrest the phagedæna; general treatment must be trusted for that. Assiduous sponging with soothing lotions are the most successful. Weak solution of borax with a little glycerine, steam with kreasote vapour, or a solution of bichloride of mercury, with one-sixth of a grain of mercury to the ounce of water, when there is great soreness and consequent spasm, are most useful. Frequent washing with the nasal douche is of great service to clear away the mucus and discharge of the nares. The gaps that are left are not promising for plastic operation. The tough cicatrices of the infiltrating variety should never be stitched. Very tight bands may sometimes be cut across, but even then the resulting scar often shrinks almost as much as it had at first. Plastic operation may be attempted to close a gap in the palate left by the breaking down of a gumma when the neighbouring tissue has lost little of its natural suppleness. But it is in nearly all cases best to wait until the contraction which follows cicatrisation has finished, and to close the diminished orifice with an obturator, which dentists now fit with great skill and success.

NOTES ON ASYLUMS FOR THE INSANE IN AMERICA.

BY JOHN CHARLES BUCKNILL, M.D., F.R.S.

(*Continued from p. 530.*)

BEFORE I pass on to another class of institutions for the insane—namely, those supported by public funds,—I shall venture to make a few remarks upon a matter which struck me very forcibly in every asylum which I visited in the States, which is that I nowhere saw any number of patients enjoying out-of-door exercise. At Boston the excuse might be made that the weather was cold, but at New York, Philadelphia, and Washington, the days of May were bright, sunny, and delicious, and such days with us would have turned out the population of our asylums into the gardens and the grounds, overflowing into the country beyond. I saw nothing of this in the States. At Bloomingdale, on a glorious genial day, I did see some male patients in one of the airing courts, but as a rule the asylum population was persistently within doors, and there were unmistakable signs that this was the habit and custom of the land. The airing courts were untrodden, and the pathways in the fine grounds but little used, like those of some absentee nobleman in our own country. Of course I mean all this as comparative only, for I did see a solitary patient now and then out of doors, but such a sight as one sees on any fine day from the Great Western Railway passing by Hanwell was totally and conspicuously absent in the States.

Moreover, in no asylum I visited did I see any adequate provision of sun-shades and out-of-door seats, and the result of my observation and inquiries was the conviction that in the United States the patients in the asylums do not enjoy anything like the amount of out-of-door exercise and recreation which it is the common custom to provide for them in this country. I think this remarkable difference is to a great degree due to the habits of the people in the two countries, the Americans, notwithstanding their splendid climate, being far less out-of-door folk than we are. Indoors they coddle themselves with cooked air, and out they do not care to budge, at least not for pleasure. When duty or business withdraws them from the stove atmosphere of the house, they encase themselves in great coats in bright, blessed weather, when an average Englishman would revel in the fresh, delicious air.

And if the inmates of American asylums do not get an adequate supply of that best and most powerful of tonics, fresh air, out of doors, they certainly do not get it within doors; for there the universal system of artificial heating and ventilation is skilfully carried out, to a pitch which to our sensations is a great discomfort. Everywhere in America the houses and hotels are heated by hot-water or steam pipes to an extent which makes them exceedingly uncomfortable to the average Englishman, who will often sleep with his window open while all the rooms and passages of his temporary domicile are filled with the hot, dry, well-fried emanations of the furnace-room in the basement, combined sometimes with a slight smack of sulphur or of oil, or of some other substance respecting which there can scarcely be differences of opinion as to whether it is agreeable or not. In the entrance hall of the Boston Asylum I observed the thermometer marking 85° F. In the best asylums the furnace system of warming is carried out very thoroughly. Generally a powerful steam-engine drives a great fan which propels furnace-heated air through passages in the basement, whence it is distributed throughout the building. There can be no doubt that the system is thoroughly efficient, and the only question which arises in my mind is whether it can be good for the patients. I ventured to express my opinion to the contrary at the Congress of the Medical Superintendents of American Asylums at which I had the privilege of attending, and I was asked the temperature at which the wards of English asylums were usually kept. I replied that I thought during winter or spring the temperature of our asylums would certainly not be above 62° F., on which Dr. Kirkbride, the authority of whose opinion in that large meeting was undisputed on all matters, said that 72° F. was the lowest temperature at which he should venture to keep his wards, and that he thought his patients would be uncomfortable in feeling and would suffer in health from any temperature below this; and his opinion certainly seemed to meet with the ready concurrence of his American brethren. Since I have returned I have found by inquiry that in all probability I considerably overstated the average temperature in our asylums, and that 52° F. would have been much nearer the mark. I thought that the inmates of American asylums did not, as a rule, bear the aspect of good physical health, certainly not as compared with the inmates of our own asylums, and I came to the conclusion that want of out-of-door life, and the habit of breathing an over-dried and over-heated atmosphere by day and by night had much to do with this appearance. I should expect that the effect of this lower range of physical health, if it exists, would be seen rather in a diminished number of cures than in an augmented mortality. The difference of habit in this respect may well be counteracted by other habits in regard to mortality—as, for instance, by the immensely greater temperance of the American people than of our own; but the existence and cure of insanity hang so frequently upon slight modifications of the bodily health that I should not be afraid of staking my professional judgment on the accuracy of the opinion that cures would be more numerous in an asylum whose inmates had the general appearance of robust health, than in another asylum whose inmates, from whatever cause, looked sallow and sickly.

I may mention "in this connexion," as Americans say, that the patients in American asylums are not allowed beer or any other fermented or intoxicating beverage as a diet. In judging of this abstention we must bear in mind the wonderfully temperate habits of the people in the Eastern States, and the fact, of which all observing men, whether they be medical men or not, assure you, that the moderate use of intoxicants cannot be borne with the same impunity in the

dry air of America, as to a great extent we enjoy in our moister climate. In this country I think it might be hazardous to abolish the moderate use of beer or wine in the diet of the insane. I am told that the experiment is being made at the new county asylum at Sheffield, and that the mortality there has been exceptionally large, whether on this account or not I cannot say, but the point is well worthy of careful observation.

The first asylum supported by public funds which I visited was the asylum for the city of Boston. It is an old and inconvenient structure in a small and cramped site, adjoining, however, the magnificent harbour of Boston, upon which, in summer time, selected parties of the patients make excursions in a steamboat provided for the purpose. The inmates were tranquil, cheerful, and many of them were engaged in various occupations and amusements; but two of them were in strait-waistcoats. It will be convenient to reserve what I have to say on this important subject of mechanical restraint until I have to make some concluding remarks. Meanwhile I may observe that this asylum was obviously under careful and skilful management, and restraint was imposed because, in the opinion, erroneous I think, of the superintendent, Dr. Walker, one of the kindest of men, it was considered best for the interests of all his patients that it should be employed. The old building is to be replaced at an early date by an adequate one on a good site in the country. The Mayor of Boston favoured me with a view of the plans, which were those of a handsome structure of long extended frontage, and architecturally very imposing; and this leads me to add a few remarks upon the plans of new asylums, or those under contemplation in the States. The Americans think much, perhaps too much, of the architectural appearance of their new asylums. The new Boston Asylum is to be one long, straight, and, it must be admitted, imposing structure. The new asylum for New Jersey is a five-storeyed building, with the mansard roof now in so much favour. The basement and the mansard storeys are, it is said, not to be used for patients. Perhaps not at first, but we know by dire experience in our own country what this intention comes to in the long run, when the increase of population presses upon supply of asylum accommodation; and at New York I saw a great number of lunatics crowded under the influence of such pressure into very miserable attics. The new asylum for New Jersey is indeed a magnificent building, and very creditable to the liberality of the State authorities, but I should have liked it better if its altitude had been decreased by two storeys, and no space had been provided for the possible overcrowding of inmates into parts of the building not originally intended for occupation. Our idea of the liberality of the authorities in providing such handsome buildings will be enhanced when we reflect that the cost of building in the United States is more than one-third greater than it is in England, a fact which I state upon the authority of the architect of the New Jersey asylum, by whom it has been carefully investigated. At Buffalo a third asylum for the State of New York is being erected on plans which pleased me extremely. The building is of two storeys, and the different wards fall back rapidly *en echelon*, leaving the central offices prominently in advance. The wards are connected with each other by semicircular glass-covered passages only fit for use as passages, and not for occupation. The plans, which have been devised by Dr. John Gray, of Utica, seem to me to combine the advantages of an asylum constructed in separate blocks, with a fine frontage, better than any others which I have seen. The plans of a new asylum for female patients in the district of Columbia have been prepared by Dr. Nichols, which resemble in general idea the plan of the new asylum at Buffalo, but the buildings connecting the blocks are intended to contain a number of single rooms, and I think in this respect they are not quite so good, because the different blocks will not be so completely isolated from each other. However, this system of separate blocks, of which I believe myself to be the originator, has been for many years a particular hobby of mine, and perhaps the plans of Dr. Nichols provide for as much separation as would content most other alienists.

The Willard Asylum for chronic lunatics chargeable to the State of New York is a pavilion asylum with a large central block for such patients as need to be kept under the immediate observation of the medical officers. I am sorry to say that I did not go over this asylum, but I heard from many of my professional brethren the highest encomiums on its management, and I am informed that the block system gives entire satisfaction. As a receptacle for chronic lunatics it seems to me to be a mistake on account of its remoteness from the great centres of population. It is quite in the west of the immense State of New York, and 190 miles from the city, and a considerable distance from the great State Asylum at Utica. A case of puerperal mania, or other acute mental disease, arising at Seneca, would have to be taken past the asylum on a long journey to Utica to be treated. Moreover, the distance from the populous parts of the State must, and, as I learnt on inquiry, actually does prevent the friends and relations of the patients from visiting them. Difference of opinion has existed among ourselves as to whether it is advisable to separate chronic and incurable lunatics from others, but I think we should all agree that it was not desirable to place the Caterham institution at Penzance.

(To be continued.)

NOTE ON THE TREATMENT OF TETANUS BY NERVE-STRETCHING.

BY GEORGE W. CALLENDER, F.R.S.,
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IN a paper read before the Abernethian Society*, Mr. Milner has advocated the treatment of tetanus by nerve-stretching, and in some observations on this operation upon nerve-trunks† I have expressed my regret, in narrating a case of tetanus, that the peroneal nerve was not exposed and stretched. Since this was written no case of traumatic tetanus has come under my care, but had the opportunity been given me I should certainly have planned an operation such as I have indicated, supposing, of course, that the nature of the case permitted me to stretch a nerve-trunk between the site of injury and the nerve-centres. I am glad to hear that quite recently M. Verneuil has had under his care in La Pitié a case which he will, I hope, shortly publish. A man had suffered from a severe crush of the hand, and, following this, showed the symptoms of tetanus. M. Verneuil exposed the median nerve at the elbow, and the ulnar at the wrist, and proceeded to exercise traction on them. The patient recovered completely.

I hope that this note may lead to a further trial of this method of treatment. The operation is not a severe one. The nerve is exposed and is stretched, when freed from its surroundings, by traction with an ordinary vulsellum, from its central connexions. No harm is likely to be sustained as a consequence. There is now abundant evidence, in the cases reported by Billroth, Nussbaum, and myself, of the tolerance with which nerves submit to forcible stretching, so far as the after-performance of their functions is concerned. In view of the unsatisfactory results of the treatment of traumatic tetanus as at present conducted, there is full justification for the performance of the operation as, at least, a last resource, although I should myself advocate its trial, as in the case under the care of M. Verneuil, as soon as the signs of the disease are distinctly recognised.

* St. Bartholomew's Hospital Reports, vol. xi., 1875, p. 287.
† THE LANCET, June 26th, 1875; Clin. Soc. Trans., vol. viii., 1874, p. 160.

HEALTH OF DUBLIN.—From the report for the quarter ending April 1st we find that the births registered amounted to 2429, or 31 in every thousand of the population; and the deaths to 2695, or 34 in every thousand. The deaths from zymotic diseases came to 440, the increase in the mortality from this class of affections being principally due to the prevalence of whooping-cough, which caused 112 deaths. Bronchitis produced 597 deaths; phthisis, 293; convulsions, 192; heart-disease, 108; pneumonia, 83; hydrocephalus, 66; fever, 64; scarlatina, 64; measles, 42; mesenteric disease, 41; diarrhœa, 33; liver disease, 30; croup, 25: whilst 54 deaths were accidental, 2 homicidal, and 2 suicidal.

ON A CASE OF

DOUBLE FEMORAL ANEURISM TREATED WITH SUCCESS BY RAPID COMPRESSION:

RETURN OF ONE ANEURISM; LIGATURE OF THE EXTERNAL ILIAC UNSUCCESSFUL; CURE BY LAYING OPEN THE SAC.

BY THOMAS ANNANDALE, F.R.S.E.,

SURGEON TO THE EDINBURGH INFIRMARY, AND LECTURER ON CLINICAL SURGERY.

MR. EDWIN MALING, of Sunderland, has very kindly sent me the following notes of this case while under his care in the Sunderland Infirmary, where the first treatment was successfully carried out.

A. M——, aged thirty-seven, boiler-maker, was admitted into the Sunderland Infirmary in May, 1873, on account of an aneurism of the left femoral artery, situated immediately below Poupart's ligament. The patient attributed the disease to a fall against an iron bolt about two months previously. After being kept in bed for two weeks, digital and instrumental pressure was, on the 21st, applied to the corresponding external iliac artery for five hours, but without success, owing to the restlessness of the patient. On the 29th continuous digital pressure was applied for seven hours and a half on the same vessel, with the result of curing the aneurism.

On September, 1874, the patient was again admitted into the Sunderland Infirmary, suffering from an aneurism of the right femoral artery, which had resulted from a blow by a piece of metal. He was confined to bed for about ten days, and on Oct. 3rd, continuous pressure, partly digital, partly instrumental, was applied over the external iliac artery for eight and a half hours, during the last three of which he was kept under the influence of chloroform. This treatment was followed by a permanent cure of the aneurism.

On the 15th of March, 1875, he was again admitted into the Sunderland Infirmary, suffering from another aneurism in the left groin. This aneurism was considered to be one of the profunda artery, and its pulsation was not controlled by pressure made on the external iliac. An operation for the relief of the disease was suggested to the patient, but he declined to submit to it, and after two months' treatment by the administration of iodide of potassium he left the infirmary with the aneurism still uncured.

Having friends in Scotland, he found his way to Edinburgh, and on the 9th of June, 1875, he placed himself under my care in the Royal Infirmary.

When examined after his admission there was found in the left groin a pulsating swelling, elongated in shape and a little larger than a hen's egg. The tumour was situated immediately below Poupart's ligament, and passed deeply into this part of the thigh, more so than is usual in a femoral aneurism in this situation. All the characteristic symptoms of an aneurism were present, and although pressure over the region of the external iliac artery diminished the pulsation in the tumour, it did not completely stay it. The external iliac artery on this side was not in its normal position, but had taken a curve downwards into the pelvis. Pulsation in the tibial arteries at the ankle was distinct, but somewhat feeble. The right femoral artery was apparently obliterated for about six inches below Poupart's ligament, and no trace of aneurism could be detected in this vessel.

As satisfactory compression could not be adopted in the present instance, the case seemed a proper one for ligature of the external iliac artery. Accordingly, on June 23rd, I secured this vessel at a point corresponding to the middle of its course. The artery was tied with prepared catgut, and the usual antiseptic precautions were employed during the operation and in the after-treatment of the wound. The immediate effect of the ligature was an almost complete cessation of the pulsation, with a diminution in the size of the tumour; but a feeble pulsation still remained in the aneurism. The patient's progress after the operation was excellent, and all the stitches were removed on July 2nd. The aneurism was now small and much firmer to the touch, but pulsation was still present, and was, if anything, slightly increasing. On July 11th direct pressure was made on the tumour by means of an india-rubber ball filled with small shot, and this pressure was continued for a few hours daily for some days, but without much good result. At this time it was found that pressure over certain parts on the inner and lower aspects of the tumour diminished very much the pulsation in the aneurism, and therefore it appeared evident that the profunda and anastomosing branches connected with it had some communication with the sac, and accounted for the non-success of our treatment. Pressure on the abdominal aorta, with and without chloroform, was next tried, and continued for several days for periods varying from half an hour to two hours and a half; but this treatment, although it slightly relieved the symptoms, made no permanent impression on the aneurism.

At this stage of the case the patient asked for a holiday, and he left the hospital on December 2nd, promising to return again in a few weeks. In the beginning of January of this year the patient returned and was readmitted into my wards. An examination at this time determined that the tumour had much increased in size, was more prominent, and had become much softer at one point. The pulsation had also increased, and the patient complained of constant and severe pain down the affected limb; he therefore begged me to do something for his immediate relief.

Having carefully considered all the circumstances of the case, I decided that the treatment most likely to cure the aneurism was to lay open the sac and secure the vessel or vessels at the point of their communication with it, and on January 11th I performed this operation, with the kind assistance of Professor Lister and Messrs. Bell and Chiene. The patient having been thoroughly chloroformed, the affected limb was held up for some minutes, so as to allow the blood to drain out of it; a common tourniquet was then applied, without a pad, tightly round the limb, immediately below the aneurism, with a view of controlling the distal hæmorrhage when the sac was opened. The abdominal aorta having then been compressed with Lister's tourniquet, I passed my knife into the centre of the aneurism, and followed it with my finger into the sac, so as to stay any bleeding which might not be controlled by the tourniquet. As, however, there was only a slight oozing from the interior of the sac, I withdrew my finger and laid the sac freely open by prolonging my incision upwards and downwards in the longitudinal direction of the thigh. When some portions of firm clot were cleared away, four openings were found to communicate with the interior of the sac, and from all of these there was slight arterial oozing. The situation of these openings was as follows:—One was at the lower end of the sac and corresponded with the distal end of the femoral artery; one was behind and to the inner side, and corresponded with the position of the profunda; one was on the inner and upper side, and corresponded apparently with the internal circumflex; and the fourth was on the outer side, and corresponded to the external circumflex. Owing to the oozing from the various openings, which was uncontrolled by the tourniquets, it would have been difficult to accurately secure these openings, had I not availed myself of a suggestion of Mr. Lister's, which was to pass into the openings metal bougies large enough to plug them, and at the same time they formed an excellent guide in dissecting round the opening so as to pass a ligature and secure the artery connected with it. In this way all the four arteries were securely tied, at their points of communication with the sac, with prepared catgut, and without injury to any important vein. After the ligature of these vessels the tourniquets were removed, and it was found that all hæmorrhage had been stayed. The edges of the wound were brought together with sutures, and antiseptic dressing was applied. The whole operation was performed under the spray and with the usual antiseptic precautions.

The patient's progress for some time after the operation was most satisfactory; the pain disappeared, and the temperature of the limb remained good. On the 22nd the edges of the wound separated, and its surface had an unhealthy appearance; his temperature also rose, and his condition gave rise to some little anxiety. On the following day hæmorrhage, to the extent of eight or nine ounces, took place from the wound, but was at once stayed by removing the dressing and exposing the parts to the air. The wound was apparently superficial, and therefore the antiseptic dressing was discontinued and boracic lotion substi-

tuted for it. No return of the bleeding took place, and his general symptoms improved, so that the report on the 1st February was that he was again quite well and the wound a superficial and healthy granulating one. From this day his progress continued perfect, and the wound steadily contracted. On the 15th February he was out of bed for the first time since the operation, and on the 20th he was able to walk about the ward and corridors. He left the hospital on the 14th March, and there was then no trace of the aneurism, and the temperature and all the movements of the limb were good.

Remarks.—The first and successful treatment by rapid compression of this case is a point of great interest and importance, and is an additional proof of the soundness of the principle that the employment of this form of compression is a simple and safe method of treating femoral aneurism, and one always to be tried, if possible, before more severe measures are adopted.

In regard to the second aneurism, which formed on the left femoral artery, I am inclined to think that it was a return of the first one cured by compression, but it is unnecessary here to discuss this question.

The most important part of this case undoubtedly is, that an aneurism of the femoral artery existed, and that ligature of the external iliac artery and pressure applied in various ways failed to cure it. The explanation of this failure to cure the disease was diagnosed before the operation to be some free communication between the sac and one or more enlarged anastomosing vessels; and the operation disclosed how active the circulation in the sac must have been through the large branches which communicated with it. A point of interest to be here noted is, that after the application of the two tourniquets arterial blood still oozed from the arteries where they opened into the sac; proving that there must have been a free anastomosis through the deep epigastric, internal mammary, lumbar, intercostal, and deep circumflex iliac vessels. The fact that the femoral artery on the opposite side was obliterated would also tend to increase the anastomosis.

My opinion is that the aneurism was one of the femoral artery, involving that portion of it which gives origin to the profunda and circumflex branches, and that (as is not very uncommon) the two circumflex branches were given off directly from the femoral, thus accounting for the four openings in the sac.

As the aneurism remained uncured, and was steadily increasing in size, notwithstanding the careful employment of the treatment which is usually successful in this disease, it was necessary to consider what means should now be tried for the relief of the patient. The patient had experienced so much treatment, and had become so disheartened, that it was important to adopt some method which would be certain. It appeared to me that only one of three proceedings was applicable in the case. The first was galvano-puncture, the second ligature of the common iliac artery, and the third to lay open the sac and secure the vessel or vessels at their point of communication with it. I decided against galvano-puncture because our present experience of it in such cases is small, and I do not think that surgeons are yet in a position to decide as to the safeness and success of this method of treatment, although I believe that further knowledge of the best means of using electricity may make it a valuable aid in some cases of the disease.

I decided against ligature of the common iliac artery because I considered it to be attended with greater risks, and also to be less certain in curing the disease owing to the free anastomosis already referred to, than laying open the sac.

I operated by laying open the aneurism because the cure of the disease was certain if the vessel or vessels could be secured at their point of communication with the sac, and because my experience of the antiseptic ligature and treatment made me very confident that the risks of such an operation were not great if the antiseptic precautions were carefully carried out.

Edinburgh.

THE will of Sir David Dumbreck, M.D., K.C.B., Honorary Physician to the Queen, who died on the 24th January, at Florence, has been proved under £12,000.

ON A

CASE IN WHICH DANGEROUS CARDIAC SYMPTOMS (FROM A BLOW) LASTED THIRTY-SIX HOURS, AND TERMINATED SUDDENLY IN CONVALESCENCE.*

BY EDWARD T. TIBBITS, M.D. LOND.,
PHYSICIAN TO THE BRADFORD INFIRMARY.

ALTHOUGH the notes of the following case are somewhat imperfect, such as they are were made at the time of observation, and I trust may be interesting.

A. C——, aged nineteen years, a grocer's apprentice, said he had been subject to attacks of "bile." On Sept. 4th, 1872, about one hour and a half after dinner, he was larking with some other youths, when he ran with great force against another man's shoulder, receiving a severe blow, as he said, "over his heart." Shortly afterwards he felt sick, and in two hours vomiting came on, which continued up to the time of my visit. Immediately after the collision he felt, to use his own words, "as if his heart were in his mouth."

Nearly twenty-four hours after the occurrence I was requested to see him, and found him in the following condition. Lying partly on the right side, his head and chest slightly raised, expression indicative of great suffering; complains of palpitation and severe pain on the left side of the chest. Action of heart visible over large area, and very tumultuous, great tenderness over the whole of this area, and can scarcely bear the slightest touch; hence I could not employ percussion or auscultation satisfactorily. Pulse very irregular in force and frequency, 160; vomiting frequent; no sleep during the whole night. The preceding notes were taken at 2.30 P.M.—5 P.M.: Palpitation, pain, and sickness continue; urgent in his cry for water or tea, either of which increases his suffering until he vomits a greenish or yellow fluid, when he dozes a few seconds. Heart's action the same.—10 P.M.: Much worse; pulse quicker and weaker; action of heart very irregular. There appears to be slight bulging of the præcordial region.

Sept. 6th.—1.30 A.M.: Apparently has not long to live; distress extreme; is very restless; pulse almost imperceptible, extremely rapid and irregular; skin perfectly dry.—2 A.M.: Was being violently sick, when he said he "felt his heart stop, give a tug, and go into its right place." "There," he added, "now I am better;" and immediately his countenance, which but a minute before wore an expression of intense suffering, became perfectly calm and placid. Half an hour afterwards he was slightly sick, but had no return of it.—10 A.M.: Quite comfortable since last visit. Lying on his back, smiling, and looking perfectly happy. Cheeks rather flushed; pulse 90, regular in force and frequency. Apex of heart impinges between fifth and sixth ribs in its normal situation. No tenderness whatever over præcordial region. Can now submit to percussion and auscultation without discomfort.

With regard to the cause of the case I have thus briefly recorded, I do not think there can be much difference of opinion. The symptoms quickly followed the blow, and although I did not see the patient until nearly twenty-four hours after the occurrence, there is no doubt the cardiac disturbance commenced almost immediately after the shock. To recapitulate, we have the following symptoms:—Expression of anguish; palpitation; visible pulsation over a large area; pain and extreme tenderness over that area; slight bulging; very quick irregular pulse, 160; sleeplessness and great restlessness; urgent vomiting. Were these alarming symptoms due to the effects of shock through the medium of the great pre-vertebral sympathetic plexuses? If so, I think we should have expected a sudden cessation of the heart's action. Or was the heart itself suffering in some way from the effects of concussion? and did it become engorged in consequence of shock to some of the small ganglia scattered through the substance of it, thus pro-

* Read before the Leeds and West Riding Medico-Chirurgical Society March 3rd, 1876.

ducing, so to speak, discordant action of its individual fibres?—a condition somewhat similar to that observed by Drs. Fagge and Stevenson, and also by Dr. F. B. Nunneley, in their experiments with digitalis and digitaline on the heart of the frog. Dr. Nunneley says: "The ventricle seems no longer to act as a single muscle, but as if made up of numerous small ones, which contract energetically, but in an irregular and disorderly manner." Presuming this to be the right explanation, could violent vomiting restore order amongst these disorderly fibres, and so produce efficient regular contraction and consequent disengorgement?—just as may be observed in some instances of irregular and, as it were, hesitating action of the uterus, where vomiting appears to produce co-ordination of the muscular action, and firm contraction is the result. The sudden disappearance of symptoms, as well as absence of murmur, would exclude rupture of chordæ tendineæ. Again, could the violence of the blow have driven the right side of the heart backwards, thus producing a slight rotation of the organ and twisting of the great vessels? The character and gradually increasing severity of the symptoms occurring so soon after the accident, coupled with their sudden disappearance during violent vomiting, seem to indicate some such mechanism. Granting this hypothesis to be correct, we could not imagine anything so likely to restore such a displacement as violent vomiting, attended as it is with full expansion and fixedness of thorax, together with distension of the right side of the heart. And here it is interesting to notice the sequence in this case. The blow produces severe symptoms, one of which is vomiting; this in its turn, if my hypothesis be correct, is distinctly curative in its action, and sudden convalescence is the result.

One word as to prognosis. Whatever view any other practitioner might have taken with regard to this case, for my own part I left the bedside thinking that, under the circumstances, there would be no difficulty in obtaining a post-mortem examination. However, the sudden relief which I have mentioned took place, and, fortunately for the patient, my prognosis proved incorrect. Perhaps I should have taken more notice of his skin, which was *perfectly dry* when I thought he had not long to live.

I did not make any notes of the treatment I adopted, and probably for this reason, that no effect, either bad or good, was produced. I believe I gave him digitalis, morphia, and a certain quantity of stimulant. Perhaps it was as well I did not interfere too much, and so retard or prevent a cure which was so quickly, safely, and pleasantly accomplished by that eminent physician, *Vis medicatrix naturæ*.

ON THE

COMPOSITION OF THE PITKEATHLY MINERAL WATERS.

(THE OLDEST MEDICINAL WATERS IN SCOTLAND.)

BY C. W. HEATON, F.C.S.,

LECTURER ON CHEMISTRY AT CHARING-CROSS HOSPITAL.

I HAVE recently had an opportunity of examining the once celebrated mineral waters of Pitkeathly, Bridge of Earn. For some years past these waters have been somewhat neglected, but they are now reviving in importance. The present owner of the estate, Mr. Grant, of Kilgraston, has taken great trouble in restoring and adding to the accommodation for visitors; the spas have now every appliance, and are regularly opened to the public at the beginning of each season. I have, therefore, thought that some account of the springs, and of the past and present composition of the waters, would be worth recording, especially as I have been favoured by Dr. James Laing, of Bridge of Earn (who has been familiar with the district for years), with some interesting local particulars.

The first notice of the Pitkeathly wells occurs in 1711, in a parish record in which it is stated that the "Session met according to appointment, and took into consideration the profanation of the Sabbath by people frequenting the medicine well of Pitkeathly." This proves that even then the place was of importance, and other incidental allusions in various places show that towards the end of the last and the beginning of the present century the spring enjoyed a considerable celebrity. Thus in an old edition of a medical work we are told that "the most celebrated saline purging springs are those of Cheltenham and Leamington in England, Pitkeathly in Scotland, and Seidlitz on the Continent." Doubtless one reason for the popularity of the waters was the remarkable beauty of the country in which they occur. Perth is only five miles away, the Ochill range close at hand, and the views from some of the surrounding hills are among the finest in Scotland. Sir Walter Scott has celebrated one of these views in the first chapter of "The Fair Maid of Perth," and Pennant described another as "the Glory of Scotland." An interesting article in the *Perthshire Constitutional and Journal*, from which I have borrowed the above particulars, tells us that from the summit of Mundie Hill, on the Kilgraston estate, we may gain "a glimpse of Edinburgh and the Bass Rock to the south, Dundee to the east, Perth and the Grampians to the north, and Ben Lomond and the Western Hills to the west." Such a view is a valuable auxiliary to a course of gentle medicine.

From Dr. Laing's notes I quote the following passage, which illustrates the geological circumstances under which the waters collect:—"The springs, which are numerous, are found in a hollow basin lying between the Ochills on the south and a slight elevation on the north which occupies the centre of the valley. Both north and south of the hollow is found a bed of old red sandstone, the one skirting the base of the Ochills, the other forming part of the rising ground referred to. These two beds, from the nature of their composition and the southern inclination of their strata, must at a remote period have formed one continuous layer, and their undisturbed position seems to indicate that the separation must have been effected by aqueous abrasion. The mineral springs are found distributed all over the low ground issuing from a thin layer of quicksand. This sand is found underneath a stratum of peat-moss, varying from ten to twelve feet in thickness, and rests on a bed of white clay. The same stratum of moss is found, spread out, at a considerable depth from the surface, over the lower part of Strathearn, and crops out at various distant parts along the bank of the river Earn, when denuded and exposed to view." Dr. Laing describes the valley as remarkably salubrious. The temperature and rainfall are moderate, and the natural drainage of the valley is excellent. Epidemic and endemic diseases are almost unknown, and the late Dr. John Thompson, of Edinburgh, even described Strathearn as the most salubrious spot in Scotland. The late Dr. M'Allum, of Edinburgh, visited it for thirty-seven successive years, and in his eighty-seventh year wrote an article on the subject.

Of the older analyses of the water, I quote, for the purpose of comparison, those of Dr. Thomas Thompson in 1839, and of Dr. Murray Thompson in 1860. I have calculated my own results in the same way, to facilitate the comparison. It is almost unnecessary to point out that agreement cannot be expected. The figures all represent grains per gallon:—

DR. THOMAS THOMPSON, 1839.

	Kilgraston.	Dunbarney.
Chloride of sodium	90·12	117·84
Chloride of magnesium	3·44	4·16
Chloride of calcium	155·28	168·58
Sulphate of calcium	12·13	25·92
	260·97	316·50

DR. MURRAY THOMPSON, 1860.

	Kilgraston.	Dunbarney.
Chloride of sodium	105·91	101·69
Chloride of magnesium	13·61	51·30
Chloride of calcium	177·65	136·08
Sulphate of calcium	5·22	5·03
Carbonate of calcium	4·80	trace
Silica	0·63	1·06
	307·82	295·16

C. W. HEATON, 1876.

	Kilgraston.	Dunbarney.
Chloride of sodium (with potassium and lithium)	77·28	152·03
Chloride of magnesium	16·67	30·60
Chloride of calcium	165·20	166·90
Sulphate of calcium	5·31	6·42
Carbonate of calcium	4·77	6·37
Silica	0·70	1·40
Ferric oxide, &c.	0·49	0·28
	270·42	364·00

	Clayton.
Chloride of sodium (with potassium and lithium)	5·77
Sulphate of sodium	23·33
Sulphate of magnesium	11·75
Carbonate of calcium	6·25
Silica	4·66
Ferric oxide, &c.	0·77
	52·53

It will be seen that the water of the Clayton spring is quite different in character from the others. In addition to notable quantities of the aperient salts, the sulphates of sodium and magnesium, it contains more iron than the others, and is, in fact, employed as a mild tonic. The most remarkable fact about it, however, is the unusually large amount of silica present in it. The presence of lithium in all three waters, found, of course, by spectrum analysis, is another interesting point, and one which tends to increase their medicinal value.

The waters have often been sent to a distance for patients who wished to continue their use after leaving; and now they are sold in bottles, aerated with carbonic acid in the usual way.

A Mirror OF HOSPITAL PRACTICE,

BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

GUY'S HOSPITAL.

A SERIES OF FIVE CASES OF OVARIOTOMY.

(Under the care of Mr. BRYANT.)

THE following notes, which have been collected by Mr. R. Carrington, late resident obstetric assistant, comprise all the cases of ovariotomy performed by Mr. Bryant at Guy's during a little more than a year.

CASE 1. *Ovarian disease; tapping; peritonitis; suppuration of ovarian cyst; ovariotomy; recovery.*—E. P——, a married woman, aged thirty-four, was admitted June 30th, 1874. She had been confined seventeen months previously, and had suckled her child for fourteen months. The catamenia had not appeared since her confinement, but her general health had been tolerably good. Four months before admission she noticed an increase in the size of her abdomen, and imagined she was again pregnant. She increased so rapidly, and suffered so much pain, that she called in medical assistance, and was tapped, and three gallons of fluid drawn off. Three months after this paracentesis was again performed, and a slightly larger quantity of fluid evacuated. She was then examined by Mr. Bryant, and came into the hospital with the wound of the last puncture unhealed.

On admission, it was quite clear that some peritonitis existed, and, judging from the constitutional symptoms, it seemed probable that disorganising changes were going on in the ovarian tumour. The pulse was 120; the temperature was several degrees beyond normal; and the abdomen was very tender.

Under these circumstances an immediate operation was proposed, and on July 18th it was performed. A long incision of about eight inches was made, and a quantity of ascitic fluid, opaque, and containing pus with flakes of lymph, evacuated. An ovarian tumour was exposed, with its surface covered with lymph, and firmly adherent to the left side of the abdominal parietes and pelvis. It was clearly polycystic. The tumour was tapped, and a quantity of fetid pus and broken-up tissue turned out. A free incision was made subsequently into the cyst, and its contents broken down. The cyst-wall was then carefully separated from its parietal and pelvic attachments, and the whole removed, this part of the operation being attended with some difficulty. The pedicle was found to be a thick one, but it was long enough to admit of the application of a clamp. This was consequently applied, and the abdominal cavity carefully sponged. A few omental adhesions were divided and ligatured, and the wound closed by deep and superficial sutures.

After the operation everything went on well. The pulse and temperature at once fell, never to rise again above the normal standard. The clamp came off on the twelfth day, and on Sept. 12th the patient left the hospital convalescent.

This case must be regarded as a very instructive one, illustrating as it clearly does the propriety of removing an ovarian tumour, the seat of disorganising changes, even when suppurative peritonitis is present. All constitutional symptoms rapidly subsided after the operation.

CASE 2. *Ovarian disease; rupture of cyst; ovariotomy; enucleation of cyst; recovery.*—M. W——, a married woman, aged forty-five, was admitted on April 27th, 1875. Her last child was born four years before, the delivery having been premature at seven months and a half. She had generally enjoyed good health, although for twelve years she had experienced a dull pain and some swelling at the lower part of her abdomen on the left side. The swelling increased very slowly, although for the eight or nine months before admission it had grown more rapidly. Three months before she was suddenly seized with acute pain at the lower part of the abdomen on the right side, and this pain lasted for twenty-four hours, and was attended with much constitutional disturbance. It then gradually subsided. For three months after this the abdominal tumour diminished in size; it then steadily increased, although the woman did not think that it ever regained its former size. She was in the hospital for ten days after the onset of the abdominal pain, under the care of Dr. Hicks, when rupture of the cyst was diagnosed.

On admission her abdomen was very large, and an ovarian cyst was felt, in which there did not appear to be much solid matter. The patient was examined on April 30th by Dr. Galabin, who reported that the abdominal tumour seemed well suited for removal, but that pelvic adhesions were probable.

May 5th.—Ovariotomy was performed by Mr. Bryant. The cyst was found to extend downwards between the layers of the broad ligament, the pedicle being obscured. By the aid of the scalpel the peritoneal covering of the cyst was divided and the cyst itself enucleated from its serous covering; a long pedicle was then brought into view, and this, together with the posterior layer of the broad ligament, was clamped and brought out through the wound, the edges of which were secured by silk sutures. The cyst was compound, containing but little solid matter.

On May 11th the sutures were removed; on the 17th the clamp came away, and on the 24th the patient went out, having made an uninterrupted recovery.

This case is of interest, as showing the practicability and value of enucleation, as without this mode of procedure it would have been impossible to have brought it to a successful termination; and this remark is probably applicable to a large number of cases.

CASE 3. *Polycystic ovarian tumour; ovariotomy; recovery.*—R. O——, a married woman, aged fifty-six, was admitted March 26th, 1875, having been sent by Dr. Carey, of Guernsey, to Mr. Bryant. Nine years before her right breast was removed, but she was told it was not for cancer. Menses had ceased four years. The previous summer the abdomen began to enlarge, and this was followed by swelling of the legs. She did not notice any definite lump on the abdomen. Her abdomen measured thirty-eight inches in circumference, was spherical in form, tense and elastic, dull on percussion in front, resonant on the flanks, and

there was the thrill of fluid. The os uteri was high up, and the cyst could be felt in front of it, and pressure on the abdomen was communicated to the finger in the vagina. Dr. Hicks examined the patient and gave the following opinion:—"Ovarian cyst, mainly simple; uterus apparently small and drawn up high; some solid tumour felt below, but all the tumour is above the brim."

April 10th.—Mr. Bryant performed ovariotomy. The cyst, which contained a large quantity of clear yellow fluid, easily emerged, there being no adhesions. The pedicle, which was rather fleshy, was clamped and secured externally, and the edges of incision brought together by superficial and deep sutures. There was but one large cyst, with the diseased ovary, which was cystic, and of the size of an orange.

The clamp came away on the fifteenth day, and the patient made a good recovery. The temperature only went as high as 100° on two occasions. On May 1st the patient went out with the abdominal wound all but healed.

CASE 3.—*Ovarian disease; puncture; ovariotomy; cure.*—T. H——, aged twenty-four, married eighteen months, admitted October 6th, 1875. She menstruated regularly. Fifteen months before she was said to have had "sciatica." Three days after the commencement of this she noticed a swelling on the right side of the abdomen, unaccompanied by pain; this gradually increased in size. She was tapped three weeks before admission, and about a pint and a half of very thick, dark fluid was drawn off. The puncture kept discharging a clear fluid for three or four days. After this she kept her bed, and had occasional sharp shooting pains at the lower part of her abdomen. On admission her abdomen was the size of that of a woman at the full term of pregnancy. A polycystic ovarian tumour was diagnosed.

On October 20th ovariotomy was performed; no adhesions existed; the pedicle was short but narrow; it was secured by a clamp. No single bad symptom followed the operation. The clamp came off on the tenth day, and she was discharged cured on November 13th, 1875.

CASE 5.—*Ovarian disease; ovariotomy; cure.*—Mrs. M——, aged twenty-six, was admitted in March, 1875, having been sent over to be under Mr. Bryant's care by Dr. Carey, of Guernsey. The disease had been coming for about one year; the tumour was polycystic, and involved the left ovary. Ovariotomy was performed on March 17th. No adhesions complicated the case, and the pedicle was moderately long. It was secured by a clamp, and a steady convalescence ensued.

The clamp came away on the fifteenth day, and the patient was convalescent on the 21st.

MIDDLESEX HOSPITAL.

ACUTE DIFFUSE PERIOSTITIS OF THE LEG; RAPID NECROSIS OF THE SHAFT OF THE TIBIA; REMOVAL OF SEQUESTRUM OF THE DIAPHYSIS OF THE TIBIA; RECOVERY.

(Under the care of Mr. GEO. LAWSON.)

THE following case, which exemplifies the beneficial effect of removing the dead bone in acute necrosis as early as possible, should be read in conjunction with those reported in the "Mirror" of the 11th ult.

Oliver P——, aged ten, was admitted into Pepys ward on June 2nd, 1875, suffering from acute diffuse periostitis of the left tibia. The history was that about two months previously he had received a blow on the left leg, a short distance below the knee, with a stone. The leg almost immediately became very painful and acutely inflamed; pus soon formed, and the abscesses were opened. The leg still continued very painful, and from two openings there had continued a free discharge.

On admission, the left leg below the knee to the foot was considerably larger than its fellow. The skin was red, shining, and boggy to the touch; and on the inner side of the tibia, at about its upper third, there were two sinuses from which there was a free discharge of pus. A probe passed into each of the sinuses came upon dead bone, and much of the enlargement of the bone was evidently due to the formation of new bone around the sequestrum. The child suffered considerable pain in the leg, was restless at night, and with small, quick, irritable pulse.

On June 5th Mr. Lawson examined the leg under chloroform, and laid open the sinuses freely to give a ready escape to the pus, which was burrowing the whole length of the leg. With the probe he could feel a large sequestrum of bone which was enclosed almost entirely with new bone, but as the sequestrum had not yet become loosened from the living bone, he decided to let the child wait for a while, until the dead portion had become more detached from the living bone.

The child received some relief from free vent having been given to the pus. He was ordered one minim of the liquid extract of opium and ten minims of solution of chinchona three times a day; and the leg was dressed with a lotion of one drachm of dilute nitric acid, three drachms of liquid extract of opium, to eight ounces of distilled water. Under this treatment he greatly improved in health, the pain almost ceased, and he gained in weight.

July 21st.—The boy was again brought into the theatre, and placed under the influence of chloroform. An Esmarch's bandage having been applied, Mr. Lawson enlarged the upper opening which led down to the necrosed bone, and cut through the new bone which enclosed the sequestrum, and succeeded in removing almost all the diaphysis of the tibia. The wound was sponged out with a weak carbolic-acid lotion and the leg placed in a Macintyre's splint. From this time patient progressed favourably. The wound slowly but steadily healed, and in the first week in November he was discharged from the hospital and sent to the convalescent hospital at Walton-on-Thames. The wound was then completely closed with the exception of two small sinuses.

Dec. 5th.—The patient on his return from Walton was readmitted into the hospital, as there were still two small wounds, one at the upper and the other at the lower end of the leg, unhealed. The leg was examined under chloroform, and some small scales of bone removed. From this last operation the patient soon recovered, and on February 21st he left the hospital to go to the convalescent establishment at Clewer.

CARDIFF INFIRMARY.

EPITHELIOMA AT ANGLE OF LOWER JAW.

(Under the care of Dr. SHEEN.)

ALTHOUGH the patient in the subjoined case died within six years of the first appearance of epithelioma of the lip, the history shows the value of operative interference. If the patient had been more diligent, and had attended properly to the advice given him, his life might have been prolonged and the disease cured.

T. B——, aged sixty-two, was admitted August 10th, 1875, with a nodulated swelling, about the size of a hen's egg, at the angle of the jaw, on the left side, and which was slightly movable. It commenced as a small nodule about twelve months ago, but had rapidly increased in size during the six weeks prior to admission.

In July, 1871, Dr. Sheen removed an epithelioma of the lip from this patient; it returned eight months afterwards, and was again removed. After the first operation he was advised to show himself again if there should be the slightest return of the disease; but he disregarded this advice, and a large portion of the lip had to be removed at the second operation. The same advice was then given him, but he took no heed of it. There was no further mischief in the lip, and, indeed, the patient had scarcely any lower lip left. There was the scar of the incision, but it was quite soft, and free from pain and swelling. The patient's health was good, and he was very plucky.

On Aug. 18th, after a consultation, Dr. Sheen proceeded to remove the tumour, under chloroform, by a triangular incision, the base of which was in a line with and above the ramus of the jaw. Only one vessel was tied. The tumour was dissected from above downwards, and was found to be closely adherent to the tissues surrounding and beneath it. It was torn from its lower attachments, the knife not being used in this stage of the operation, and just as the tumour was taken away there was a tremendous welling up of venous blood, apparently from the bottom of the deep large

wound. Pressure with a small sponge stopped the hæmorrhage, but it recurred three or four times when the pressure was removed, and so quickly that no vessel could be seen. Dr. Sheen succeeded, however, in grasping between his finger and thumb a portion of tissue from where the blood appeared to issue, and the hæmorrhage at once ceased. This was held for a few minutes, and turned out on examination to be the anterior border of the sterno-mastoid. There was no further bleeding. Just before this, the patient was very restless, partly from loss of blood, and partly from semi-consciousness of pain. A hypodermic injection of one-sixth of a grain of morphia stopped this restlessness almost at once. (The good effect of this treatment was very noticeable.) After the removal of the tumour a large deep wound was left, at the bottom of which the carotid could be seen distinctly pulsating within its sheath. The stylo-hyoid and digastric muscles, with the hypoglossal nerve running across the space, were clearly shown as if after a minute and elaborate dissection. A square inch of the ramus of the jaw was bared of periosteum. The edges of the wound were brought together with hare-lip pins as well as the loss of skin would permit.

On the 31st he was up and felt "first-rate." The wound had filled up considerably and looked healthy. On October 5th he was made an out-patient. There was still an unhealed irregular surface of about an inch, with one or two suspicious-looking spots about it and some gluey discharge, but no pain. Bare bone at the bottom. Much contraction of surrounding skin. General health very good.

A few months later he passed successfully through a severe attack of erysipelas of the face whilst in the country, after which the disease increased rapidly, and he died in March, 1876, of exhaustion, about six years after the first appearance of disease in the lip.

A similar case to this occurred recently at Guy's Hospital, and was operated upon by Mr. Durham. It is reported in the *Guy's Hospital Gazette* of November 6th, 1875.

ROYAL HOSPITAL FOR SICK CHILDREN, EDINBURGH.

CASE OF TRAUMATIC TETANUS, FOLLOWING INJURY OF THE KNEE; AMPUTATION THROUGH UPPER PART OF THIGH; RECOVERY.

(Under the care of Professor SPENCE.)

THE desirability of removing the peripheral source of irritation in traumatic tetanus was very clearly shown in the following case, for the notes of which we are indebted to Mr. J. Milne Chapman, M.B. It is, however, important not to overlook the admonition contained in the appended note by Professor Spence.

Wm. M——, aged five, was admitted, under the care of Dr. Macdonald, on February 19th, 1876. A month prior to admission he fell from the back of a cart, and was drawn along the ground, receiving what was described as a deep wound over the inner aspect of the left knee. A stitch and simple dressing was all the treatment employed. From the first the inflammation spread superficially, and three weeks after the accident the knee began to swell. For some time before entering the hospital it was observed that his mouth was stiff, and that he could not swallow any solid food.

On admission, an ulcerated area about the size of the palm of the hand extended upwards from the level of the left knee-joint, with which it communicated at its lower part by an opening through which the inner condyle of the femur could be distinguished, exposed and roughened. The patient's general health was much impaired, but his appetite remained good. The temperature was 102° F. He was ordered a draught containing ten grains of chloral along with fifteen grains of bromide of potassium, but yet he passed a very restless night.

Feb. 20th.—Morning temperature 100°. In the afternoon, while retracting his tongue, his jaws closed on it, and on its being freed the teeth snapped together. Temperature in the evening 103°. At eight P.M. he had an attack of opisthotonos, which lasted about two minutes. He was at once put under chloroform. Professor Spence, who was called in consultation, expressed the opinion that on account of the injuries alone, amputation was required. He accordingly, at 8.30, performed amputation through the middle third of the thigh by a long anterior and two shorter posterior flaps principally composed of skin. No sutures were used—merely three strips of plaster to retain the flaps in position, and the stump was covered with a single layer of lint soaked in carbolised oil. During the operation the child had two attacks of spasms, while under chloroform. The condyles of the femur were found to be split into the knee-joint, and the joint itself was filled with purulent fluid. Twenty grains of chloral were at once administered, but on coming out of chloroform he had attacks of opisthotonos every ten minutes for about two hours, when twenty grains more were given. The interval of rest then extended to forty-five minutes. After each spasm he had five grains of chloral, and on three occasions hypodermic injections of three, five, and seven and a half minims of solution of the sulphate of atropia (B.P.)

21st.—Slept soundly for about three hours in the morning. During the day he had four spasms, at intervals of about two hours. He took milk and chicken soup freely.—At 10 P.M., he had a very severe attack, which lasted for five minutes. Seven minims and a half of atropia were injected, and a spinal ice-bag applied.

He slept soundly, and had no more tetanic symptoms, except on one occasion, when Prof. Spence, observing a fixed expression on his face, ordered an atropine injection. His appetite continued good, and he was soon able to eat solids. The chloral was kept up, however, in diminishing doses for about a week. The temperature fell to 98·6° on the second day after the operation, and continued to range between 98° and 99° for nine days, when a considerable rise took place, coincident with the appearance of a measley rash. By the 14th of March, the face had lost all its pinched appearance, and the stump was almost entirely healed by primary union.

Note by Professor SPENCE.—In recording the foregoing case as a contribution to the treatment of a very obscure disease, I would not wish to be understood as indicating the opinion that amputation would be successful in arresting the tetanic symptoms in all cases where they arise from lesion of a limb, by removing the cause, and cutting off the continuity between the irritated peripheral nerves and the nerve-centres. Such an opinion would require much larger foundation than a single successful case.

I have frequently performed amputation of lacerated fingers in tetanus, but without any benefit, although the operations were performed early in disease. Indeed, the progress of cases of traumatic tetanus would rather lead to the view that when the symptoms fairly manifest themselves certain changes have already occurred in the nerve-centres which the removal of the originating cause comes too late to benefit. But the case just recorded warrants me, I think, in saying that no remedial measures could have relieved the patient unless the injured limb had been removed; and, in so far, the amputation must be regarded as a main part of the curative measures. In this case the disorganised state of the knee-joint left no room for hesitation; but, from my experience of tetanus, I believe the irritable and ulcerated cutaneous surface was the real exciting cause, and the result of this case would certainly encourage to amputate in similar cases even where the local injury was less severe.

CAMBRIDGE UNIVERSITY REFORM.—A memorial, signed by a number of professors, fellows, &c., has been forwarded to Mr. Disraeli, urging the following reforms in reference to Cambridge University:—No fellowship should be tenable for life, except when the original tenure is extended in consideration of services rendered to education, learning, or sciences actively and directly in connexion with the university or the colleges. A permanent professional career should be as far as possible secured to resident educators and students, whether married or not. Provision should be made for the association of the colleges, or some of them, for educational purposes, so as to secure more efficient teaching, and to allow to the teachers more leisure for private study. The pecuniary and other relations subsisting between the university and the colleges should be revised, and, if necessary, a representative board of university finance should be organised.

Medical Societies.

ROYAL MEDICAL AND CHIRURGICAL SOCIETY.

THE ordinary meeting of this Society was held on April 11th, Sir James Paget, President, in the chair. The evening was devoted chiefly to the discussion of an interesting point in pathological histology—viz., the mode of development of spindle-cells in "nested sarcomas," afforded in a paper by Dr. Gowers, whose observations go far to confirm the statements of Dr. Creighton as to the part played by vacuolation in the tissue changes. Dr. Thin, whose views are totally opposed to these conclusions, again maintained the position he took up at the previous meeting of the Society, that cell-proliferation does not occur, but that all new formations are due to out-wandered leucocytes, a view to which Mr. Hulke raised some cogent objections. Dr. Evans exhibited a patient suffering from lichen ruber.

The paper communicated by Dr. GOWERS was entitled, "On the Development of Spindle-cells in Nested Sarcomas." The tumours thus designated consisted of spindle-cells with a few round cells, and had, further, this peculiarity—viz., that the spindle-cells were in part arranged concentrically in nests, resembling very closely the nests of epithelioma. The microscopical characters of the cellular elements were fully detailed. The nuclei of the cells were larger in proportion to the size of the cell in the softer and more rapidly growing parts of the tumour, while in the denser portions the cells were finer and more like fibres. In some parts, round cells were observed in process of development into the spindle-shaped varieties. The "cell-nests" varied from $\frac{1}{170}$ of an inch to $\frac{1}{12}$ of an inch in diameter, and were distinctly seen to be composed of concentric layers of fusiform cells, the outermost layers being in many specimens partly detached. These observations were founded upon three examples of the tumour which sprang from the inner surface of the cranial dura mater; they were globular and nodulated, and had displaced the brain-substance in their vicinity. They varied in consistency, but the older portions of the growths were firmer than the more recent parts, and in one specimen the whole tumour was soft throughout. In colour the growths were of a reddish-grey, the softer parts resembling in tint and consistency grey cerebral substance. In these tumours the origin of their constituent spindle-cells could be readily traced; the process being found to consist in an endogenous development from round cells, the process described as vacuolation by Dr. Creighton. The following is a brief outline of the changes as observed in different stages of progress in different parts of the growth. The nucleus of the small delicate-walled round or oval cell, which is at first in or near the middle of the cell, becomes excentric in situation, whilst a clear space occurs in that part of the cell which is away from the nucleus; and as the cell increases in size its granular protoplasmic contents become more and more confined to the periphery, till at length the "crescentic" or "signet-ring" form of cell is produced. The nucleus now lies imbedded in the protoplasm where this is thickest. Gradually the inner margin of the crescent-shaped body becomes more defined, until at length there is produced a spindle-cell, which gradually separates from the central mass of the original cell-body. Many were seen in process of separation, and in those recently detached their crescentic shape denoted the manner in which they had arisen. When the original nucleus remains single the spherical cell only gives rise to a single fusiform cell; and if the nucleus divides after it has acquired its lateral position, the resulting spindle-cell contains two nuclei. But occasionally the division of the nucleus takes place before or soon after the process of vacuolation commences, and in this case one nucleus remains behind within the hyaline area, and is often surrounded by some granular protoplasm. It may here be developed into another cell, thus lying within the first spindle-cell. The repetition of this process by repeated multiplication of the nuclei produced the concentric nests. This process of vacuolation can only be distinctly seen in the rapidly growing portions of the tumour, and it was only distinct in fresh specimens. The exact nature of the process and of the hyaline contents of the vacuoli is uncertain. It would appear that these contents are composed of some new, delicate material, at first protoplasmic. The process may be regarded as a simple movement of the nucleus and granular protoplasm to the periphery of the cell, but the sharp outline of the vacuoli and the tenuity of the periphery suggest that there is an active distending force concerned in the process. Vacuolation in most cases terminates the active life of the original cell; and division of the nucleus only leads to multiplication of the cell if it precede or accompany, not if it succeed, the vacuolation process. The paper concluded with a reference to various descriptions and drawings of the process by different writers, who have, however, for the most part misinterpreted its nature. The examples show how various is the part played by the process in tissue changes. The paper was illustrated by a series of well-executed drawings.—Mr. KNOWSLEY THORNTON had recently examined carefully some specimens of peritoneal cancer, and had found numerous vacuolated cells surrounded by rings of protoplasm. He had never seen anything like an intrusion of other cells into the vacuoli; and concurred with the view maintained by Dr. Gowers as to the endogenous formation of the new cells. In some specimens a round cell presented central vacuolation, an excentric nucleus surrounded by granular protoplasm, within which a development of small cells appeared to be taking place. Staining reagents brought clearly into view the darker granular mass bounding the cell, and this mass seemed to be undergoing a process of cleavage. He had not been able to trace, as Dr. Thin had, the cells to their original starting place, but in the peritoneum he had noticed projections of oval or round masses of granular material from the stomata, surrounded by germinating endothelium. He could not satisfy himself as to the origin of this material.—Dr. THIN agreed with Dr. Gowers that the process of vacuolation was not a new discovery. He had, however, never heard it so explicitly stated as on the present occasion. Had Dr. Gowers disintegrated any of the large "nested cells," and did he believe that division of the nucleus was essential to the formation of the second cell? With regard to Mr. Thornton's remarks, he was surprised that the ideas of stomata and lymph-canalicular systems should be so generally adopted. Many able histologists, including Ranvier, had denied the existence of these stomata. Nor did he (the speaker) believe in the germination of epithelium. With regard to endogenous cell-formation, all its appearances were explained by the entrance into the cells of leucocytes, a process which he was convinced did occur. He had devoted much time and labour to enable him to recognise lymph-corpuscles, and he thought he could recognise in the drawings accompanying Dr. Gowers's paper evidence in support of his view.—Mr. HULKE said that he would receive with very much hesitation the statement that leucocytes have such a remarkable tendency for wandering into the tissues and into other cells. In a leucorrhœal discharge one found numerous large definite squamous cells, containing, not one, but two, three, or four definite rounded bodies, which certainly were not leucocytes. He instanced also the case of suppuration of the vitreous humour, enclosed in its definite hyaloid membrane, and separated from the choroidal capillaries by the membrana limitans and the whole thickness of the retina and the pigmentary epithelium and elastic lamina of the choroid, and thought that the travelling powers required by the leucocytes to penetrate all these structures were more than could be granted. On the other hand, the vitreous possesses traces of fœtal structure, vestiges of embryonic cell-tissue, which can be seen distinctly to be enlarged and replaced by bodies indistinguishable from pus-cells. He was then very sceptical about the enormous powers which were attributed to the white blood-cells.—Dr. GOWERS, in reply, remarked that Mr. Knowsley Thornton's observations on the multiplication of nuclei in the peripheral zone of vacuolated cells were interesting. He had not observed such multiplication after vacuolation, and asked whether they might not have been formed before vacuolation, and pushed to the periphery by the process. In reply to Dr. Thin, the character of the outer cells of the nests could be seen readily, since one or two were often half detached;

they were simple spindle-cells curved according to the shape of the globe. He could not accept Dr. Thin's view that the second nucleus within a vacuolated cell was a leucocyte which had wandered in. The nucleus resembled closely the original nucleus of the cell. If a nucleus were seen in a certain position, he thought that the first inference suggested was that it had been formed there, not that it had wandered in. This inference was strongly supported by observation of the nests of cells, since there was a simultaneous increase in the number of nuclei in the centre and of spindle-cells in the outer part of the nest. But the more numerous the circumferential cells, the greater the obstruction to the entrance of cells from without; and it was therefore probable that simultaneous increase in the nuclei within was due to their formation at the spot, and not to their migration from without.

Dr. G. H. EVANS introduced a patient suffering from Lichen ruber, in which the eruption covered nearly the whole of the trunk, presenting the characteristic papulo-squamous features. He remarked upon the rarity of the disease in this country, and quoted Prof. Hebra's account of the affection.—Sir J. PAGET pointed out that the case exhibited very fairly the characters of a symmetrical eruption.—Dr. THIN remarked that the case had reached the stage at which the papules had become aggregated. He had seen two such cases when in Vienna, and in each of them, as in the present, each papule was surrounded by a layer of epidermic scales. The successive crops of papules were sufficient to diagnose the case from one of psoriasis. In other cases the skin was infiltrated and hard.—Dr. F. TAYLOR had lately seen two cases somewhat resembling this. In one, that of a boy twelve years of age, there was an eruption of fine shiny papules on the shoulders and back, combined with a thick scaly eruption, with a red base, upon the legs. The case was considered as one of psoriasis. The other case was that of an infant in which the eruption resembled lichen ruber rather than strophulus. He noticed in Dr. Evans's patient some pigmented patches which lichen ruber usually leaves behind it.

The Society then adjourned.

PATHOLOGICAL SOCIETY OF LONDON.

THE ordinary meeting of this Society was held on the 18th inst., Mr. George Pollock, President, in the chair. After the President had announced an invitation to members of the Society from the International Medical Congress at Philadelphia, and paid a tribute to the memory of Mr. Campbell De Morgan, the Society resumed its usual work. Most of the specimens exhibited at this meeting dealt with questions of interest in abdominal medicine and surgery—e.g., those exhibited by Drs. Fagge and Goodhart and Mr. Baker, and a few of them gave rise to discussion. Besides these, Dr. Pye Smith brought forward an interesting case of chronic hydrocephalus due to injury; and Mr. McCarthy showed a specimen of disease of the intervertebral substance with double psoas abscess.

At the commencement of the proceedings the PRESIDENT informed the members that an invitation had been received from the United States, to the members of the Pathological Society of London, to attend the International Medical Congress, shortly to be held in Philadelphia; and he requested those gentlemen who were desirous of availing themselves of this invitation to send in their names to the Secretaries. The announcement was received with marks of approbation.

Mr. POLLOCK again rose and referred to the heavy loss recently sustained by the Society in the death, most deeply deplored, of Mr. Campbell De Morgan, one of the Society's Vice-Presidents. He said that everyone who had been connected with Mr. De Morgan, whether privately or professionally, appreciated the excellent qualities shown by him as a surgeon, a man of science, and a gentleman. Personally he had know Mr. De Morgan for many years and had enjoyed many opportunities of admiring his excellence as a man of honour and integrity. There were very few who had laboured so much to maintain the honour of the profession. Mr. Pollock concluded his remarks by submitting to the meeting the proposition of the Council, conveying to the family of Mr. Campbell De Morgan their sense of the great loss which the Society and the profession have sustained by his death.

Dr. HILTON FAGGE exhibited a specimen of Contraction of the Small Intestine, due to peritoneal adhesions. It was removed from the body of a girl nine years of age, who was admitted into Guy's Hospital on April 7th. She had been in good health to within thirteen days of admission, when she began to suffer from abdominal pain and vomiting. The bowels were then opened, but constipation followed, lasting nine days. When admitted she was in a state of collapse, the abdomen was distended and tympanitic, and on its surface coils of intestine could be distinctly seen from time to time, when a sort of spasm occurred in the abdominal wall. Stercoraceous vomiting set in shortly after admission, and every day on exposing the abdomen the spasm referred to came on, and the intestinal coils, which maintained throughout their position, and showed no peristaltic movements, became evident. This fixity in position and absence of movement led Dr. Fagge to believe that there were some old adhesions binding the bowel to the anterior abdominal wall. Death supervened upon the careful administration of an enema, which caused much pain, and was returned. The post-mortem examination revealed recent acute peritonitis, without any ulceration or perforation of the large intestine, and the seat of obstruction was found to be high up in the small intestine, a coil of which was adherent to the under surface of the liver. The bowel was here much narrowed and somewhat twisted. Other old adhesions occurred between portions of the canal. The mesenteric glands were caseous. Dr. Fagge remarked that the case was an example of intestinal obstruction not often met with—one of a class which he had styled "contraction of intestine," in which the gut was not actually strangulated, but was narrowed by being bound down by adhesions. In the present case it was evident that the girl must have suffered from chronic peritonitis of long duration, and it was elicited after her death that she had occasionally suffered from pain in the abdomen for several years. The absence of peristalsis was not due in this case to adhesion to the abdominal wall, as surmised during life. He alluded also to the circumstances attending the fatal issue—viz., the onset of acute peritonitis and collapse following an injection, without any local lesion.—Dr. WILKS referred to a suggestion made some time ago by Dr. Fagge—namely, that when the intestinal coils are well-marked through the abdominal wall, the case is probably a chronic one, and that in such cases the muscular coat of the intestine is hypertrophied. The long duration of cases of this class was of very great importance, and he thought all these examples of recurring obstruction came under this head. In illustration Dr. Wilks mentioned the case of a gentleman, who eventually died of chronic peritonitis, in whom similar attacks occurred at intervals from the age of six months.—In reply to Mr. Godlee, Dr. FAGGE stated that the distended coils of intestine above the stricture would probably occupy the whole of the front of the abdomen, so that peristalsis, if visible, would be seen over the whole surface.—Mr. WAGSTAFFE suggested that thinness of the abdominal walls might render the coils of intestine visible, equally with thickening of the coats of the bowel.—Dr. FAGGE did not think the greater or less tenuity of the abdominal wall sufficient by itself to render the coils visible—e.g., in acute obstruction; and that visible vermicular movements were an indication of chronic obstruction.

Dr. PYE SMITH related a case of Injury to the Head with Chronic Hydrocephalus, and showed specimens of the cranium and brain. The patient, a man thirty-five years of age, was admitted into hospital, under the care of Dr. Wilks, last November, in a semi-comatose condition. He contracted acute rheumatism when in the hospital, and died eventually from endocarditis affecting the aortic valves and pleurisy. When admitted, the following history was obtained:—At the age of twenty-seven he fell into a sawpit and struck his head, lying for two days in an insensible state. He apparently suffered no symptoms from this injury; but four years later he was again injured on the head by a fall of a brick, which produced a scalp wound, the scar of which

remained. Eight weeks before his admission he became subject to attacks of *petit mal*, occasionally with loss of consciousness and twitching of limbs. This condition lasted for nearly three months. A short time before his admission he had a "fit," followed by insensibility, and another fit when he came under Dr. Wilks's care. Beyond his insensibility, there were no definite symptoms pointing to the nervous system, except slowness of pulse, which varied from 68 to 40. There was no loss of memory, and during his stay in hospital—about five months—no recurrence of fits. The condition of the cranium and its contents was as follows:—There were fourteen ounces of effusion into the lateral ventricles, without softening of the central parts or change in the ependyma, and there was no obstruction in the straight sinus or veins of Galen. There was some thickening of the arachnoid in places, and patches and spots of rusty pigmentation (hæmorrhagic) on the right temporo-sphenoidal and parietal lobes. On the right side of the occipital bone, continuous with the lambdoidal suture, was a fissured fracture partially united, which extended down to the mastoid portion of the temporal bone. The foramen magnum was of an oblong shape, its long diameter being transverse. Dr. Pye Smith added that the interest of the case lay in the long-standing accumulation of fluid in the ventricle with absence of symptoms, and in its probable connexion with the cranial lesion. All cases of chronic hydrocephalus could be relegated either to those where there was direct obstruction to the venous outflow, comparable to ascites from portal obstruction, or to those dependent on chronic inflammatory conditions, as in chronic peritonitis. In this case no obstruction was found. The disappearance of nervous symptoms might be accounted for on the hypothesis that the brain had become accommodated to the effusion, which in its early stages had led to the production of the fits.

Dr. CRISP exhibited a specimen of Acute Meningitis in a Child, with symptoms of three days' duration; and suggested that the case was one of traumatic origin. The brain only was examined. He also showed a specimen of a Fatty Tumour from a Fowl, remarking that this was the first example of such a growth in lower animals yet recorded.

Mr. MCCARTHY brought forward an interesting specimen of Disease of the Intervertebral Substance, with Psoas Abscesses. The specimen, which showed softening and suppuration of one of the lumbar intervertebral discs, communicating by two small sinuses with a psoas abscess on each side, was obtained from the body of a railway porter who, six months before his death, had "strained his back." He only desisted from work one month before death, and was admitted into the hospital in a moribund condition. An abscess in the right thigh, believed to communicate with the hip joint, was opened before death. At the post-mortem examination, the cavity of the joint was found distended with pus, but not communicating with the abscess, which proved to be a large psoas abscess. On the left side the psoas muscle was nearly destroyed, the abscess here terminating above Poupart's ligament. The vertebræ were healthy, but examination showed disease of the intervertebral discs. Mr. McCarthy remarked that such a condition probably accounted for those cases in which remnants of psoas abscesses were found without any vertebral disease; cases attributed by Mr. Bryant and others to inflammation of the psoas muscle. Probably had this patient rested early after his accident the disease might have been arrested, and the abscesses become obsolete; while cicatrisation of the disorganised intervertebral substance would have left no trace of the primary mischief.—Mr. HOWARD MARSH referred to a specimen in the St. Bartholomew's Hospital Museum, where all the intervertebral discs had disappeared, without any disease of the vertebræ being present.—Dr. FAGGE suggested that the disease of the hip-joint was secondary to the psoas abscess by means of the bursa over the joint.—Mr. MCCARTHY could not find any communication of the hip-joint with external parts, but did not doubt that the suppurative arthritis was secondary to the inflammation in its vicinity.—Dr. GOODHART referred to a case in which the hip-joint was laid open by a psoas abscess. He also stated that the Museum of the College of Surgeons contained a specimen similar to that mentioned by Mr. Marsh, in which the whole of the intervertebral discs had gone. The specimen was from a child who showed no spinal symptoms during life. Many cases of vertebral disease he believed commenced at the points of greatest strain—viz., at the junction of the intervertebral substance and the bone.—Mr. MARSH related a case in which a psoas abscess had opened into the aorta. This occurrence was marked by a rapid increase in the size of the abscess, with symptoms of internal hæmorrhage. The sac of the abscess contained an admixture of pus and recent blood-clot.—Mr. POLLOCK said that Mr. Marsh's case recalled to his mind one in which he had diagnosed a similar accident, but in which he was unable to obtain a post-mortem examination. The psoas abscess in this case had not descended below Poupart's ligament, and the indications of its rupture into the aorta were afforded by increase in the size of the abscess and discolouration of the skin from extravasated blood.

Mr. M'CARTHY then showed a specimen of a Communication between the Vermiform Appendix and the Rectum, discovered post mortem, and of interest as showing how by contracting adhesions with the lower bowel fatal perforation of the appendix was sometimes avoided. The perforated appendix in this instance depended into a cavity in the submucous tissue of the rectum, which communicated with the gut by two small fistulous openings. He had met with one other example.

Dr. GOODHART exhibited a specimen of Obturator Hernia, obtained from the body of a woman, sixty-five years of age. The symptoms dated from May, 1875, when she was admitted under the care of Mr. Bryant, suffering from constipation of nine days' standing, and pain in the left side of abdomen. She was emaciated, and coils of intestine were visible through the parietes. Peristaltic movements were noticed. After treatment by opiates she left the hospital apparently well, but was readmitted in December with recurrence of symptoms of obstruction. She had now double, but reducible, femoral hernia, but had no symptoms pointing to obturator hernia. Repeated examination per rectum failed to establish any evidence of malignant disease, but she gradually sank, dying on February 4th. There was found suppurative peritonitis, and an obturater hernia on the left side, including nearly the whole circumference of the bowel (small intestine), which was firmly adherent to the sac. There was some ulceration opposite to the seat of obstruction. Dr. Goodhart remarked upon the long duration of the obstruction, and referred to cases recorded by Messrs. Hilton and Birkett, in which the onset of pain in cases of obturator hernia long preceded evidence of sudden obstruction. In such a case as the present operative measures would have certainly failed to afford relief, judging by the light of the post-mortem examination. He noticed also the fact that such hernias were seldom diagnosed, and that it was not uncommon for emaciation to occur in old subjects.

Dr. GOODHART further exhibited a Bladder eleven years after Lithotomy. It was removed from a lad fourteen years of age, who was cut for stone at the age of three, and had ever since suffered from incontinence of urine. The specimen did not throw any light upon the question of the incontinence which now and then occurs after lithotomy. There was a large scar at the base of the bladder, with obliteration of the right vas deferens, and displacement of the verumontanum to the left of the median line. Possibly the muscular fibres composing the sphincter were impaired by the cicatricial thickening.—Mr. MARSH had met with a few cases of incontinence following lithotomy in children; one had fallen under his own care. It was that of a boy three years of age, in whom the operation was attended with no difficulty, and the wound healed rapidly. Some years later the child was brought to the hospital suffering from incontinence; there was constant dribbling. He made a careful examination without detecting the cause of this. Drugs had no effect on it, and the child left the hospital unrelieved. It was important to note that the incontinence might follow cases where there was no difficulty about the operation, whereas in others in which much injury was done no such event ensued. He could give no explanation of its occurrence. Had Dr. Goodhart microscopically examined the muscular fibres or nerves at the base of the bladder?—Dr. GOODHART replied that the muscular fibres were quite natural. He had not examined the nerves.—Mr. POLLOCK said that he had had a similar case in a child in which the operation was uncomplicated.

Mr. MORRANT BAKER showed a specimen of Ulcerated

Intestine from Strangulated Hernia. The case was one in which a femoral hernia on the right side, of twelve years' standing, had become strangulated five days before admission. It was reduced by operation, but death ensued in twenty-four hours from perforation of the intestine, not at the seat of strangulation, but two feet above this, where the bowel was much ulcerated. Mr. Baker referred to enteritis and ulceration of the intestines following obstruction, but he thought that in this case the ulceration had existed long before the obstruction due to the hernia, which he regarded simply as the determining cause of the perforation.

The Society then adjourned.

OBSTETRICAL SOCIETY OF LONDON.

AT the meeting on Wednesday, April 5th—Dr. Priestley, President, in the chair,—before entering upon the general business of the evening, Dr. MURRAY wished to bring forward a resolution, "That the Obstetrical Society of London present a vote of thanks to Dr. Arthur Farre, Dr. Barnes, and Dr. Priestley for having resigned their posts as Examiners in Midwifery at the Royal College of Surgeons in the interests of the science and practice of obstetrics." He had little to say on the subject, as the matter had been prominently before the profession for some little time, but he did think that a permanent record should be made of the steps which these gentlemen had taken. He could not but admire the unhesitating resignation of Dr. Barnes, and although Dr. Arthur Farre, being their honorary president, was hardly expected to take an active part in the matter, he entered into it with much feeling. Dr. Priestley, who doubtless was placed in a position which required some amount of reflection, could come to no other determination. Dr. Murray considered the College authorities very unfair in trying to put on these gentlemen so unjust and so unprecedented a task, which, to their honour and credit, they have declined to perform. The licence in midwifery was considered to be an additional qualification, but never intended to stand alone, and, so to speak, place partially educated persons on a level with those who had or could obtain a complete and perfect medical education. He hoped that the example now set would deter any member of the profession from accepting the posts which have been vacated.—Mr. WORNSHIP, of Sevenoaks, seconded the resolution. He thought the thanks of the profession were eminently due to these gentlemen for their energetic protest against the course proposed by the College, which if carried out would enable a number of half-educated men to practise midwifery nominally without restricting them from practising other branches of the profession, and would thus place the general practitioner in a most unfair position. He deeply regretted that such a scheme should have been proposed during the presidency of Sir James Paget, who had always hitherto striven to elevate the education of medical men. He considered this a very retrograde movement.—The resolution was carried by universal acclamation.

Dr. BARNES regarded the course he had taken a plain duty. Looking neither to the right hand nor to the left, but solely to the future, he had regarded the course proposed by the College as detrimental to the interests of the profession and injurious to the public. It was a matter of intense gratification to him to see that his conduct was approved by his brother practitioners, and he expressed his thanks to the Society for the way in which they had received him. One great grievance was that we had no representative voice at the College of Surgeons or Physicians, and our only mode of expressing an opinion was by doing so outside through the Society. He trusted that no one would be induced to take the examinerships. We had only to act steadfastly together, and the College must give in.—The PRESIDENT hoped the Society would excuse him if, in the present position of the question, he expressed very briefly his thanks for the resolution which had been carried by such acclamation. He might say that he had entire sympathy with the resolution which had been drawn up by the Council, and forwarded to the College of Surgeons, as a protest against admitting partially qualified persons to the Medical Register, but he had been placed, as Dr. Murray had pointed out, in a double difficulty, being anxious, on the one hand, as President of the Obstetrical Society, to give effect to the resolutions passed by the Council, and on the other hand, as an old examiner of the College of Surgeons, being reluctant to behave discourteously to the College, or to obstruct its authorities in attempting to render obedience to the law as it had been expounded to them. On full consideration, however, he and Dr. Farre had come to the conclusion that the College proposed to impose a duty upon them as examiners under circumstances which had never occurred before, and they had consequently asked to be relieved of their functions at once. He believed he might be permitted to say for Dr. Farre as well as himself that it was a great gratification to know that their conduct in this matter met with the approval of the Fellows of the Society and of the medical profession generally.

Dr. D. C. MACCALLUM, of Montreal, communicated through Dr. Wiltshire the particulars of a case of Remarkable Development of an Infant, occurring in the practice of Dr. Cameron. At birth the child weighed 14 lb. When twelve months old she weighed 69 lb.; her height was 35½ inches, and she was 30 inches round the chest. She was not weaned until two years old, when she commenced to walk. At seventeen months she weighed 98 lb.

Dr. MACCALLUM also communicated a case of Complete Obstruction of the Bowel from Intra-uterine Peritonitis. Distension of the fœtal abdomen retarded delivery. The anal aperture was normal, but nothing passed. Stercoraceous vomiting ensued, and death resulted on the fifth day. At the autopsy numerous thick and strong extensive adhesions were found matting the intestines together. About six inches from the ileo-cæcal valve, a tough band was found stretching across the bowel, forming a practically impervious stricture, and almost amputating the intestine. There was no history of syphilis.—Dr. HAYES had never met with intra-uterine peritonitis of the fœtus as the result of congenital syphilis, nor had he seen peritonitis after birth occur in infants affected with this disease.—Dr. BARNES stated that he had seen general peritonitis in infants affected with syphilis, but whether it was due to this latter he could not say distinctly.

Dr. A. E. AUST LAWRENCE (of Clifton) exhibited a Placenta, with unusual arrangement of vessels. The umbilical cord, instead of passing to the centre before it distributed its vessels, was attached to the amnion for three inches previous to arriving at the margin of the placenta. There was a fibrinous deposit under the amnion, which, together with an old blood-clot, had produced sufficient adhesion between the placenta and uterus to necessitate manual removal. There had been much abdominal pain during the last three months of pregnancy.—The PRESIDENT suggested that the specimen should be added to the museum.

Mr. E. CHILD exhibited a specimen of Extra-uterine Fœtation. The sac had been removed post mortem from a patient who, whilst hanging out clothes, had been seized with colic, and had peritonitis following. Death eventually occurred. The fœtus, fully formed, about three inches in length, was discovered at the autopsy lying in a sac formed apparently by the left ovary, and the intestines matted together above, and Douglas's pouch below. The patient had previously suffered from a severe attack of colic, but, though married, had no suspicion of being pregnant. Shortly before her death hæmorrhage occurred, and she passed a mass per rectum, which was apparently the lining of the cyst.—The PRESIDENT inquired whether any decidual membrane was present in the uterine cavity.—Dr. AVELING suggested that it was probably the decidual membrane which had been passed before death.—Dr. EDIS stated that he had what he believed to be two cases of extra-uterine fœtation under observation just now. In both, violent pains in the abdomen, described as colic, were prominent symptoms. The catamenia were regular to time, but less than usual. The uterus was pushed over to one side, and there was a progressive development of the growth presumed to be extra-uterine fœtation. He thought the case related by Mr. Child one of much interest, and that it would be well if practitioners would place on record interesting cases of this nature that might serve as landmarks for future guidance.—Dr. PLAYFAIR inquired what treatment was proposed in these cases.—Dr. EDIS replied that the cases had only recently come under observation, and were attend-

ing as out-patients. One refused to remain in the hospital, and the other had gone off to the country. He had since heard that this latter had had a severe attack of "inflammation of the bowels," her life being despaired of, though she was still lingering.

Dr. OSWALD exhibited a Tumour removed post mortem from a patient aged forty-two, mother of six children. The growth had been observed some ten months; it had rapidly increased, causing much pain, and had been diagnosed during life as malignant. It appeared to proceed from the right ovary. Under the microscope numerous cancer-cells were detected.

(To be concluded.)

Reviews and Notices of Books.

Cyclopædia of the Practice of Medicine. VON ZIEMSSEN. Vol. V. Diseases of Respiratory Organs. A. Buck. 1875.

THIS volume is the fifth of Ziemssen's valuable Cyclopædia, though the fourth has not been issued. It contains articles by four writers — namely: 1. Pneumonia, by Jürgensen. 2. Anæmia, Hyperæmia, Hæmorrhages, Atelectasis, Emphysema, Atrophy and Hypertrophy of the Lungs, by Hertz. 3. Pulmonary Consumption, by Ruehle. 4. Chronic and Acute Tuberculosis, by Rindfleisch. Jürgensen divides his subject into croupous pneumonia, catarrhal pneumonia, hypostatic processes in the lungs, and pneumonia from embolism. Like every German work of this kind, Jürgensen's account is very full and exhaustive, with a certain order and method about it, which renders it easy to consult. Still, in comparing it with one of those given by our own writers, as by Dr. C. J. B. Williams in the "Cyclopædia of Practical Medicine" published in 1834, or by Dr. Walshe, we have been surprised at the slight advances that have been made. Much of what is true in Prof. Jürgensen's article is old, and of that which is new a good deal is disputed. No doubt the indications to be derived from thermometry are important additions to our knowledge; no doubt some advances have been made in regard to the pathology of the disease. But putting these aside, we are not sure that the student would not gain a clearer conception of the disease from Williams, Walshe, or from Watson, than from Jürgensen, though his is a far longer and more laboured account.

Amongst the more important facts noted by Jürgensen are, first, that in pneumonia the pulse-respiration ratio is always different from the normal; the ratio in health being $\frac{1}{4}$, whilst in pneumonia the respirations tend to become proportionately more rapid than the pulse. Secondly, he draws attention to the palpatory percussion of the chest, recommended and practised by Wintrich, and founded upon the greater or less sense of resistance which the thorax communicates to the sense of touch, the resistance being always increased at the points where the hepatised lung-tissue lies in contact with the walls of the chest. Thirdly, he devotes a section to the condition of nutrition in pneumonia, showing from Riesell and Huppert's observations the amount of nitrogen excreted in excess. Fourthly, he maintains, though it appears to us there is little to be said in support of the view, that pneumonia is an infectious disease, caused, like typhoid fever, by a special exciting cause. He supports it, however, by pointing out that during the whole course of pneumonia there is no constant relation between the local and the febrile symptoms, nor dependence of the one upon the other; and, further, that pneumonia, or, as he calls it, croupous pneumonia, is a disease which runs a typical course closely allied to that of the acute infectious diseases. He considers that the danger in pneumonia threatens principally the heart of the patient, death resulting from insufficiency of the heart, which is again due to the increased resistance to the pulmonary circulation caused by the exudation. In the treatment he accordingly pays especial attention to the indications derived from the pulse. He lowers the increased temperature by baths or the employment of the wet sheet at from 60° to 80° F., giving a little wine before and after, conjoined with a large dose (thirty grains to a drachm or more) of quinine every evening. Otherwise, in the large majority of cases, his method of treatment is essentially expectant—that is to say, he maintains the life of the patient till the disease has run its course, and then aids the recovery by judicious nutritive measures.

In Hertz's article on Pulmonary Emphysema the etiology of the disease is referred to coughing and other forcible movements of expiration, though we are of opinion that many arguments might be advanced in favour of its resulting from, or at least being connected with, disease or compression of the bronchial arteries. He strongly recommends the treatment by inhalation of compressed air, which can be pursued in the institutes of Lange in Dresden and of Marck in Reichenhall. Dr. Buck appends a note, in which Hanke and Berkart's method of employing compressed and rarefied air in the treatment of disease is described.

The articles by Ruehle on Pulmonary Consumption and Acute Miliary Tuberculosis, and by Rindfleisch on Acute and Chronic Tuberculosis, appear to have been written with great care and a thorough knowledge of the subjects. Both accept the inoculability of miliary tuberculosis, either from without, as in experiments on certain animals, as the rabbit, or as the result of absorption from caseous foci; and Rindfleisch calls attention to the remarkable similarity between the predisposition of certain animals to tuberculosis and the almost exclusive occurrence of tuberculosis in a special group of persons—the scrofulous. He observes further that *fresh* scrofulous exudations contain relatively large cells with glistening protoplasm and a segmenting or double nucleus. He thinks that the emigrated white corpuscles of the blood have in scrofulous persons a tendency to grow larger on their way through the connective tissue. They swell up by the intussusception of albuminous substances, and in this very swelling die and slowly degenerate. The formation and transportation of the tubercular poison are, he thinks, probably effected by the formation and transportation of this detritus. The great peculiarity of scrofulous inflammation is the strong tendency to cellular infiltration of the connective tissue, causing this tissue to become a hard, dense, grayish, half-translucent mass, which constitutes the acme of the process. In such masses the bloodvessels become occluded, and then necrotic processes ensue. The relation of scrofula to tubercle is succinctly given in the following chain of reasoning. Scrofulous persons are especially predisposed to tuberculosis, tuberculosis, in fact, scarcely ever occurring except in scrofulous persons; tuberculous phthisis is only a combination of scrofulous inflammation and tubercles; whilst in scrofulous persons an inflammation brings with it the risk of tuberculosis. Lastly, the cheesy infiltrations and suppurations of mucous membranes elaborate a poison which, when absorbed, produces tubercles. The tubercular poison in most cases is thus manufactured by the patient himself, and it has not yet been demonstrated that this poison can be transmitted to perfectly healthy persons, so that the disease can hardly be considered purely infectious.

In discussing the etiology of pulmonary consumption Ruehle lays great stress on the importance of fresh air, remarking, in language that would satisfy Dr. H. McCormac himself, that "we still assign more airy rooms to our handsome furniture than to human beings, especially children."

On the whole, this volume is a valuable addition to our literature. May we add: is it not advisable, even in a business point of view, that the several volumes should be separately purchasable? Why should those who are practising one branch of medicine be compelled to purchase ten or twelve volumes at a guinea a-piece, the leaves of which will never be cut? Our wealthy American cousins may think nothing of £15, but in England it is a consideration!

On the Pathology and Operative Treatment of Hip Disease. By THOMAS ANNANDALE, F.R.S.E., F.R.C.S.E., Surgeon to the Royal Infirmary, Edinburgh, and Lecturer on Clinical Surgery. Edinburgh: Maclachlan and Stewart. 1876.

IN this pamphlet of some fifty pages is presented, in a connected form, a reprint of some papers that have already appeared. The first chapter discusses the pathology of hip disease, the second the operative treatment, and the third the method of operating and the after-treatment. The opinions held by different well-known authorities on hip-joint disease are freely quoted. The author's experience leads him to the conclusion that, although hip disease may originate in the synovial membrane or pelvic bones, it most frequently commences in the head of the femur. He details twenty-two cases of operations: fourteen recovered completely, with movable joint; three recovered from the operation, but died within eighteen months from visceral disease; five died—one fifteen months, one twelve months, one five months, and one two months—from the combined results of the operation and visceral complication. This is a fair success, and is attributed to the employment of the antiseptic treatment and to the performance of excision in an early stage of the disease. Thirteen cases were treated antiseptically, and nine non-antiseptically; all the former recovered, and the latter, with one exception, are classed as unsuccessful. In addition to the antiseptic treatment, De Morgan's solution of chloride of zinc was applied to the exposed articular surface or bone. One point is strongly insisted on—that is, when symptoms of suppuration are either present or doubtful, an antiseptic exploratory incision should be made to ascertain the condition of the joint, and early excision performed when the head of the femur is found diseased. In seventeen of the cases no external sinus existed, although there were signs of it, and suppuration in all. Of the seventeen four were unsuccessful, but were not treated antiseptically.

There is nothing novel in the author's method of operating; the after-treatment adopted was of the simplest kind—support by sandbags and pillows, extension by means of a light weight when necessary. Gentle movement of the joint is resorted to in three weeks' time if there be no counter-indication. Four to five months is laid down as the average time that is required for recovery after an operation.

The various pathological appearances occurring in hip-joint disease are exceedingly well depicted in numerous illustrations from specimens in the author's collection. The value of most of the successful cases is enhanced by the fact that the condition of the patient, after a considerable period has elapsed from the date of the operation, is stated.

On Fermentation. By P. SCHÜTZENBERGER, Director at the Chemical Laboratory at the Sorbonne. London: Henry S. King & Co. 1876.

THIS translation forms one of the now well-known international scientific series. Almost every volume of the series is good, and the present is no exception to the rule. It is an admirable little monograph, arranged with the simplicity and written with the clearness so characteristic of the best French books. Within its proper limits it is almost exhaustive. After a short historical sketch, the different kinds of fermentation are discussed in turn, and the latest discoveries in regard to each explained. In the chapter on the functions of yeast a full account is given of the beautiful method of estimating dissolved oxygen, invented by the author shortly after his discovery of the true sodium hyposulphite, and its remarkable power of absorbing free oxygen. A great part of the book is of course occupied with the researches and views of Pasteur, and in the last chapter his experiments with regard to spontaneous generation are fully described. This part of the work is, however, injured by the absence of all reference to recent English experiments, many of which have been, as our readers are aware, of great importance.

The work of translating has been fairly well done, but the text is disfigured by an unnecessary number of *errata*.

Gerichtsärztliche Gutachten. Erste Reihe. Von Dr. HERMANN FRIEDBERG. Braunschweig: F. Vieweg und Sohn. 1875.

DR. FRIEDBERG, who is Professor of Medical Jurisprudence at Breslau, has collected a series of the investigations which it has been his duty to make in a public capacity into the cause of death in cases in which an inquiry has been necessary. The details of each case are described with great fulness and with scientific method, their bearing fully discussed, and the grounds for the verdict explained. They constitute so many clinical studies, of value to the physician as well as to the medical jurisconsult, for they are described as fully in their clinical as in their legal aspect. Thirty cases are described in the first series, and they include various forms of injury and of disease. Among them are many cases of fatal injuries to the brain, and of heart affections, rupture of the heart, spontaneous and traumatic, and cases of poisoning by arsenic, brandy, carbonic oxide, &c. Every case discussed is a model of careful systematic description.

A Short History of Natural Science, and of the Progress of Discovery from the time of the Greeks to the present day. By ARABELLA B. BUCKLEY. John Murray. 1876.

A WELL-WRITTEN, accurate, and comprehensive synopsis. The author shows sound knowledge of each of the chief branches of physical science, and writes in a pleasant style, removed at once from dulness and from flippancy. She has evidently compiled with care and from a wide range of authorities, and has shown great judgment in selecting the leading discoveries of each age and in each science. She has, moreover, a remarkable power of lucid explanation, and even with difficult phenomena, as the polarisation of light, generally contrives to be intelligible, which is saying a great deal. Although the book is modestly described as intended "for schools and young persons," it may be read with pleasure and profit by the great majority of adults.

Annotated Poems of English Authors. Edited by the Rev. E. T. STEVENS, M.A. Oxon., and the Rev. DAVID MORRIS, B.A. London. Longmans and Co. 1876.

AN excellent series of choice compositions, selected from standard English authors, for the use of pupils of the second grade and elementary schools. Each poem is prefaced with a brief sketch of the author's life, and a short criticism on the poem, accompanied by numerous explanatory and critical foot-notes. Milton's "L'Allegro" and "Il Penseroso," Gray's "Elegy," and Goldsmith's "Deserted Village," have been already published in this series, and with the aid of the accompanying notes and annotations, written as these are in simple language, there is no reason why these poems should not be read with intelligence and appreciation.

THE LANCET.

LONDON: SATURDAY, APRIL 22, 1876.

THE correspondence which has lately appeared in our columns has expressed the desire, which is pretty generally felt, that the Universities of Oxford and Cambridge should afford increased facilities for graduation in Medicine. Some of our correspondents have indicated the form they would wish this extension to take, and although we are not prepared to recommend the measures many of them suggest, there is little doubt that a liberal concession of some points on the part of the universities is becoming daily more imperative, if they would retain, or rather regain, their position as leading centres of medical education. The most valuable concession would be the shortening the period of university residence. At present three years of residence are required at either University before the student can proceed to a degree in Medicine. This might, we think, with advantage be reduced to two years, or eighteen months. Such an arrangement would place the students of our profession more on an equality with those of the Church and the Bar than is now the case. The theological student can complete his studies at the University and then pass direct to his curacy, and the law student whilst at college can also keep his law terms in London. The medical student can, indeed, pursue his professional studies at the University, but few do so, and the majority of the medical students come up to London and enter the hospitals as first-year's men, and thus in reality commence their medical education afresh. The reason of this lies in the fact that the Universities can never, under present conditions, thoroughly carry on the work of medical tuition. This is not because the professors there are in any respect behind their London brethren, for the names of PAGET, HUMPHRY, ACLAND, and ROLLESTON forbid such a supposition; but because no inducements are offered for a sufficient number of young men to remain and engage in the work of medical teaching. Experience shows us that the success of a school depends upon the energy and devotion of its younger members, and practically Oxford and Cambridge have no junior medical staff. But if Oxford and Cambridge do not offer favourable opportunities for the prosecution of purely medical studies, there can be no doubt that scientific teaching and study could be immensely developed within their walls. Nor can we conceive a greater boon than that such training should be made available to every student entering our profession. But to make it available the hitherto impracticable barrier of too prolonged a residence ought to be removed. Let us suppose that a student who had passed any of the Arts examinations recognised by the Board of Medical Studies be allowed, on passing a preliminary examination in science, to enter at the University. During the eighteen months of his stay there he would attend lectures on human and comparative anatomy and physiology, chemistry, and botany; at the conclusion of his term of residence he would be examined in these subjects, and, if successful, his name placed either in the pass or honour list. The Honour examination might be considered equivalent to the present Natural Science Tripos, and should give the successful candidate the privilege of proceeding to the B.A. degree. After this examination the University education would be completed, and the student free to pursue his purely medical studies at any well-known school of medicine, the final examination for the M.B. taking place not sooner than two years after leaving the University. This examination should also be both pass and honour. This arrangement would give good men an opportunity of distinguishing themselves in the class lists, whilst second and third-rate men would be stimulated to work for a University degree if they felt that in the Pass Examination they were not subjected to an ordeal more severe than the ordinary examination, say of the College of Physicians. But while we would recommend a moderate test for candidates for the M.B. degree, which might be regarded as a high qualification for general practice, the examination for the M.D. should be made as severe as for any existing degree in Medicine in the kingdom. We believe if the period of residence at the Universities were shortened in the way we have indicated, the time would speedily come when the bulk of our profession would receive their preliminary education either at Oxford or Cambridge. Eighteen months at either University would confer all the social advantages to be gained from college life, whilst the time would be too short to encourage idleness or extravagant habits. The Universities would widely extend their influence; they would do for Medicine what they have done for the Church; and we should have scattered throughout the kingdom a body of practitioners who had enjoyed the same social and intellectual culture as their fellow-labourers—the country clergymen; while the standard exacted for the highest degree—the M.D.—would ensure that its possessors were in no way inferior to those who in past times have made that title illustrious.

THE Council of the Royal College of Surgeons have at length been forced to adopt a course of action with respect to the certificate of qualification in Midwifery which they ought to have spontaneously pursued many months ago. It will be remembered that in December last, when the question of the desirability of admitting women to the examination for the certificate of qualification of Midwifery was first raised, it was very properly referred to the standing counsel to advise and report upon. The legal advisers of the Council of the College reported that, according to the 17th clause of the Charter of the 15th Victoria, the Council had not power to refuse to examine any "person" who should be otherwise eligible, and that therefore they could not legally decline to examine any woman who had fulfilled all the requirements of the regulations relating to the examination in Midwifery. A few of the influential members of the Council at once accepted their fate, and were apparently unwilling to oppose any measures that the advocates of medical women should deem it expedient to suggest; and although there were a few members of Council who were not

content to allow the matter to be so easily settled, the opposition was neither lasting nor determined. When the certificates of three students at the London Medical College for Women were presented to the Council, they were referred to the President and the Vice-Presidents for perusal. It was finally alleged that these certificates were satisfactory—that is, in other words, it was alleged that the female students in question had actually produced evidence "of having been engaged during at least four years in the acquirement of professional knowledge; of having completed, at recognised schools, the professional education required of candidates for the diploma of member of the College; of having attended one course of lectures on Midwifery and the Diseases of Women and Children; and of having personally conducted thirty labours." But although the certificates of the ladies were pronounced satisfactory by the President and Vice-Presidents, we believe that the majority of the members of the Council have not yet been informed whether these certificates exhibited exact compliance with the prescribed regulations. When we consider that the ladies referred to did not complete their medical education at Edinburgh, and that the London Medical College for Women, with which they are now identified, is not a *recognised school*, it is scarcely necessary to insist that the burden of proof lies with those who have decided that the certificates should be accepted as sufficient and satisfactory.

Happily, however, the Council of the College have been saved from the effects of the weak, wavering policy of expediency of their leaders by the prompt and praiseworthy conduct of Dr. BARNES, one of the examiners in Obstetrics. When it was announced that the Council was willing to admit women to examination in Midwifery, Dr. BARNES at once declined to examine "persons" who were not properly and adequately educated, and he accordingly tendered his resignation. Later on Dr. FARRE and Dr. PRIESTLEY were induced to follow Dr. BARNES's lead. The result is that at the quarterly meeting of the Council on the 13th inst. it was resolved, "That Mesdames JEX BLAKE, THORNE, and PEACHEY should be informed that the members of the Board of Examiners in Midwifery having resigned their offices, the Council are obliged to postpone the holding of examinations for certificates of qualification in Midwifery; that the President and Vice-President be deputed to request an interview with the Lord President of the Privy Council for the purpose of stating to his Grace the difficulty which their Council finds in fulfilling the duty imposed on it by the 17th Clause of the Charter of the 15th Victoria, and of suggesting that the names of persons holding no other qualification to practise than that of a certificate or licence in Midwifery should be placed in a separate list in the Medical Register." It would appear that the Council of the College has already begun to realise some of the evils which we predicted. From the full effects of these it has been to a large extent saved by the spirited policy of Dr. BARNES and the effectual though tardy acquiescence of Dr. FARRE and Dr. PRIESTLEY.

The question is, after all, one of medical education, and one which the Medical Council will be soon called upon to consider. Either a modification in the objectionable clause should be made or a new charter should be asked for. But perhaps the simplest way of settling the matter is to expunge the clause altogether, if that be possible.

THAT example is better than precept is universally acknowledged, and to take a concrete instance of an abstract truth we should say that the noble example which Miss NIGHTINGALE set the ladies of England some twenty years ago is very superior to the somewhat rambling and incoherent precepts which during the past week she has put forward in *The Times*. Miss NIGHTINGALE'S literary style sadly lacks conciseness and clearness, and it is really no very easy task to be sure of the exact nature of the scheme which she advocates at such length. Miss NIGHTINGALE'S wish seems to be to extend very greatly a system which already has some slight footing among us, and to establish in different parts of London "homes" for women of superior education who are willing to undertake the nursing of the sick poor in their own abodes. These nurses are intended to be not only nurses in the proper sense of the word, but missionaries of sanitation, and reporters to the authorities of any insanitary conditions which they may encounter. The idea seems to us to be in every respect excellent, and worthy of encouragement, but we confess that we do not see the way quite clearly to the successful elaboration of the details.

The first point that occurs to us is, What class of cases is the nurse to visit, and under whose authority is she to act? It is conceivable that a district nurse might work under the auspices of the parish authorities, or that she might work hand-in-hand with the district visitors and the clergy, or that her labours might be carried on under the banner of some such body as the Charity Organisation Society. If, however, the "Metropolitan and National Nursing Association" are going to act independently, it is difficult to see how they will set about their labours. Are they, for instance, to seek out the sick poor, or are the sick poor to come in search of them? The poor do not mind and do not scruple to come to a hospital, and get medicine or advice, or even board and lodging, for they know that no inquiries will be made, and that no prying into their domestic condition will follow without their wish or consent. If, however, a district nurse spies out the filthiness of a home, and makes a report which brings down inspectors *et hoc genus omne*, we know enough of the poor to be certain that the district nurse is likely to become a most unpopular personage. The poor are exceedingly intolerant of anything like interference with their private arrangements, and they have seldom the patience to look to the motives (and even if they do, they have a wonderful knack of misunderstanding them) which have caused such interference to be made. We sympathise most heartily with that independent spirit which causes the poor to resent the intrusion of strangers, albeit that we know it often constitutes a most unreasonable barrier to many a well-intentioned act of charity.

Miss NIGHTINGALE'S letter is wonderfully vague, and we much wish we could have some particulars of the *modus operandi* of the Society, such as the number and nature of the cases attended in the past year, the mode in which they were first brought under the notice of the Society, together with some other particulars, such as the position of the house, the wages, the number in family, and occupations of

the patients. We should also like information as to the income and expenditure of the Society, the nature of the relief afforded, the amount paid by the patients, &c. With such information one might be able to form some conclusions as to the feasibility of the scheme, but Miss NIGHTINGALE's very shadowy statements afford little ground for useful argument.

There can be no doubt that among the very poor, among such as would be considered proper objects for the kindly ministrations of a district nurse, the dwelling-rooms are such as are scarcely habitable even for the healthy, and such as never could under any circumstances become proper habitations for acute or chronic invalids. Doubtless the district nurse, in her rôle of sanitary missionary, would teach the advantages of ventilation and cleanliness, but the fact must not be lost sight of that in many cases the dirt and squalor is no fault of the occupiers, but rather is inherent in the construction of the houses. What woman, for instance, even though she have the muscles of a Hercules, and all the enthusiasm of a religious devotee, could grapple with the disadvantages to be met with in some of the dwellings in Soho, where families of six or eight live up five pairs of stairs, in less than 1500 cubic feet of space, while the one water-tap to which they have access is in the very basement under the pavement; where there is no separate watercloset or sink, and where consequently the possibility of being cleanly is not to be thought of? We do not for a moment doubt that a thoroughly trained nurse is capable of teaching many a useful lesson while she is attending in a poor family, so that possibly for the future the family in question might lead a far more wholesome existence; but it is only too obvious that all the knowledge in the world will not be able to effect those radical changes which are necessary in most of the dwellings of the poor, but which we hope to see brought about by the provisions of Mr. Cross's Bill.

Under existing conditions we are not sure that the poor, whose circumstances are such as to compel them to live in unwholesome dwellings, ought to be in any way encouraged to stop in their own homes during sickness. Removal to a cheerful hospital, where they may receive not only the best of nursing, but many a hygienic lesson as well, which they may carry home with them, seems to us to be the best course. A sick person and a nurse as additional dwellers in a room too small for its ordinary inhabitants, even when in health, seem to us to entail a needless aggravation of trouble; and when the period of disease is closed by death, and the poor survivors are left to inhabit for a time the same room as the corpse, their misery is aggravated a hundredfold.

If we turn from the very poor to those in better circumstances, the class of warehousemen and clerks—the class who have some education, but who for the most part perform their own domestic work and keep no servant,—we are ready to admit that for these the possibility of obtaining a skilled nurse during sickness, at a small charge, would be an unmitigated blessing. To this class sickness, which not only entails great expense, but many hardships also, is a great trial, and any movement which should have for its object the alleviation of their trials in such a way that the acceptance of help should not involve any loss of self-respect, would be a movement worthy of the warmest sympathy and the most active support.

Miss NIGHTINGALE asks for £20,000 and an income of £5000 for the proper carrying out of her scheme. This is a sum more than sufficient to build and permanently endow a hospital of one hundred beds. It is a sum which would go a long way towards any improvement scheme which should have for its object the removal of unhealthy dwellings and the substitution of healthy ones.

We know well the amount and the kind of benefit which hospitals and improved dwellings confer upon the poor, and we know that all the activity shown during the last ten years in erecting wholesome houses has failed utterly to keep pace with the demand. We are still very much in the dark as to the amount of good which district nurses are capable of effecting, and the amount of permanent benefit would, at any rate, if any, only be of the same kind as that effected by an improvement in the dwellings. Of the two, we should feel inclined to think that the admission of air and light and the provision of a water-tap and a sink and other necessaries for each tenement, would be more practically useful and more conducive to improved hygiene than many women who, in spite of training and an ability to take temperatures and scientific notes, might not always be a welcome addition to a small household. We have no wish to throw cold water unnecessarily on Miss NIGHTINGALE's charitable schemes, and it is possible that when we are in possession of more particulars we may be entirely in favour of them; but pending the publication of the particulars, we feel very jealous lest the charity of the public should be diverted from channels where its utility has been proved to others the benefi of which is at the best a matter of speculation.

DROPSY arising from central obstruction to the circulation is by no means infrequently met with. The condition of heart most favourable to the production of systemic dropsy, dilatation and tricuspid regurgitation, may, however, exist with very slight or even no accompanying anasarca. Indeed, provided the blood is in a healthy state, general dropsy cannot occur. The moment, however, deterioration of the vital fluid is brought about, an obstruction to the flow of blood through the heart may cause considerable dropsy. At the same time, the dropsy arising from central obstruction never, so far as we are aware, amounts to great uniform general anasarca, such as was found in Mr. LAWSON TAIT's case of fœtal dropsy. On the contrary, such dropsy always occurs in the adult from disease of the kidneys. In both these cases—dropsy arising from central obstruction or from disease of the kidneys—the condition of the blood plays a most important part. Further, general anasarca may occur in children without any local lesion to account for it; the subjects of it are, however, highly anæmic, and the dropsy is slight. In all cases, then, of general dropsy in the adult the condition of the blood itself plays a not inconsiderable part. We cannot doubt that similar causes would act in a similar manner in the fœtus, and that the effect of obstruction to the flow of blood through the fœtal heart would be a certain amount of damming up of blood in the vessels, leading to the obstruction, which would be felt first at the most distant

and least supported part—that is, in the placenta. What now would be the effect of closure of the foramen ovale? We must premise that in many cases the valve of the foramen ovale is so large at birth that it is capable of completely closing that orifice, provided the valve were applied to the foramen. This application of the valve is not accomplished before birth, inasmuch as the current from the inferior cava is directed against its right surface, and thus maintains the patency of the orifice, while no counteracting force is applied to the left surface of the valve. Immediately after the first inspirations, however, the conditions are altered; the blood from the right ventricle is driven through the pulmonary arteries, along the pulmonary veins, into the left auricle, and the auricle becomes filled. A new force is thus applied to the left surface of the valve of the foramen ovale, and the orifice becomes closed as far as the current of blood is concerned; thus closure of the foramen ovale, by means of its valve, may take place suddenly at birth (though actual closure of this opening does not take place for several days, or even years) without causing any serious obstruction. Serious obstruction, then, due to closure of the foramen ovale, would not arise in the right auriculo-ventricular orifice, but possibly the ductus arteriosus would offer some obstruction to the passage of perhaps a double quantity of blood along its channel. In considering this point the shortness of the duct and the strength of the right ventricle should be borne in mind; and when we remember that there is no reason for supposing the closure of the foramen ovale in Mr. TAIT'S case to have taken place rapidly, we cannot regard the obstruction arising from this cause as considerable. It appears to us that the whole of the obstruction arising from closure of the foramen ovale could not have been great, that it may have been sufficient to cause œdema in the loose tissue of the placenta, but that it was not an efficient cause of the dropsy described by Mr. TAIT. In a former article we gave some reasons for thinking that the fœtal dropsy was due to œdema of the placenta—inasmuch as the placenta acts probably as a kidney in depurating the fœtal blood. We will add some more reasons which appear to us to favour this view. The urine of the fœtus has been examined by several observers, and it appears to vary somewhat in character. It is usually bloody and albuminous. In some instances uric acid and a nitrogenous substance have been found in it, but urea has always been absent. Most writers on physiological chemistry state that the liquor amnii at term contains variable quantities of renal secretion, though SCHERER has not found urea in it. Again, the urine of the pregnant woman has been found somewhat variable. Some inquirers have found that the urinary salts diminish towards term, while the majority have found them maintain their normal proportion to the weight of the woman. Analyses of this kind are of little value unless made with due regard to surrounding conditions, regimen, peculiarity of the woman, &c., and moreover their value would be greatly enhanced if they could be compared with the urine of the same woman while unimpregnated. If, however, as the majority of observers state, the urinary product maintains its normal proportion to the weight of the woman, then there is an actual increase in proportion to the increase in weight of the uterus and its contents—that is, the woman secretes a greater quantity of urine during pregnancy than she does in the unimpregnated state. These three considerations—the increase in the urinary secretion of the pregnant woman, the small and variable quantity of urinary salts in the fœtal urine, and in the liquor amnii—seem to us to point to a urinary outlet other than the fœtal kidney, and that is the placenta. But there is another condition, a consideration of which tends to the same conclusion—that is, the albuminuria and dropsy of pregnancy—a condition which rapidly disappears after labour. This condition, when not due to disease of the kidneys, independent of pregnancy, has been explained by congestion of the kidneys caused by pressure from the enlarged uterus. Now, we question much if the uterus is ever so large as to exercise such pressure on the renal vessels, because many cases are met with in which ovarian tumours have attained a much greater size than that of the gravid uterus at term, and yet the urine has contained no trace of albumen. Besides, the albuminuria of pregnancy comes on about the sixth and sometimes as early as the fourth month, a time when it is not possible for the uterus to interfere by pressure with the circulation in the kidney. It seems to us more probable that the materials removable by the kidney are removed from the fœtal circulation in the placenta, that they enter the maternal blood, and that the maternal kidneys are unequal to the increased task imposed upon them. If, then, the placenta acts the part of a kidney to the fœtus, the dropsy observed in the case in question becomes explicable, for the placenta, having become œdematous, could but imperfectly perform its functions. The fact that the child was born alive proves that the placenta had not been impaired in its function to such a degree as to cause the death of the fœtus, but does not prove that its functions were normally performed, any more than the fact of an attack of acute bronchitis not resulting in death proves that the lungs during that attack performed their functions efficiently. Closure of the foramen ovale seems to us quite inefficient as a direct cause of the anasarca described, though indirectly it may give rise to such a condition.

Annotations.

"Ne quid nimis."

THE SPREAD OF INFECTIOUS DISEASES BY THE OUT-PATIENTS OF HOSPITALS.

THE risk of the dissemination of infectious diseases among the patients and their friends congregated in the out-patients' rooms of hospitals has not unfrequently been urged as one argument, among others, against existing hospital arrangements for the treatment of out-patients. Another phase of this question has recently been brought to our notice which appears to us to demand the consideration of the governing bodies of hospitals. It appears to be the rule in several of our general hospitals, if a case of infectious disease is discovered among the out-patients—scarlet fever for example,—simply to dismiss the patient, directing him to apply either to the London Fever Hospital or to take measures to obtain admission into one of the Metropolitan Asylums Board Fever Hospitals. We are told, on what we believe to be good authority, of patients discovered among the out-patients with the scarlet-fever rash

fully out upon them having been sent from both University College Hospital and from St. Bartholomew's, to *walk* to the London Fever Hospital, and who have walked there, the only caution given to them being not to enter an omnibus or cab. Surely it is discreditable to our great hospitals that, after the recognition of infectious disease within their precincts, no proper provision should be made, if the case be not retained for treatment, to prevent its further mischievousness by diffusion of infection. There should be no difficulty in dealing with a case of this kind, whether it be sent to the London Fever Hospital or to one of the Metropolitan Asylums Board Hospitals. At the London Fever Hospital an ambulance waggon is always to be procured, by means of which patients can be conveyed through the streets safely. The cost of telegram and horse would fall with almost inappreciable lightness upon the funds of the general hospital. The public then may fairly require from the governing bodies of our hospitals that proper arrangements shall be made for dealing with cases of the kind we have described. It may be a question whether some legal responsibility does not rest upon the governing bodies of hospitals with respect to the exposure of cases of infectious disease among their out-patients; but we apprehend that this is one of those questions that have escaped attention, and need only to be brought into notice to be set right.

FLOGGING, FOOTBALL, AND ROWING.

UNDER this heading we propose briefly to answer a few questions and objections raised by our correspondent "Head Master." In reply to what punishment we propose to substitute for corporal, we would say, drill—not in the seductive form of playing at volunteers, but good steady extension drill. Punishment drill is said to be held in great detestation by the soldier, and we see no reason why the schoolboy should not similarly dislike it. We remember in our school days the weekly visit of the drill-sergeant, though the drill took place in regular school hours, was always abhorred. Drill has the advantage over impositions of keeping the boy in the open air and affording plenty of exercise; it cannot be shirked. We fancy few boys would care to lose many half-holidays in such employment, and the sight of others at cricket, football, &c., would add bitterness to his reflections. The additional expense of the drill-master might be met by a levy on the offenders' pocket-money. With regard to "Head Master's" observations on football, we agree that the Rugby game is more dangerous for young men than for boys with respect to immediate accidents, but we have no hesitation in saying that the excessive strain that the game played after the Rugby rules entails on young and growing frames often acts very injuriously, and lays the foundation of future disease in after-life. In his first letter "Head Master" quoted Mr. M'Laren ("Physical Education") against our statement that rowing is an exercise that favours the development of the arms and upper region of the trunk. During the recent visit of the Universities' crews we had an opportunity of witnessing them in practice, and we have come to the conclusion that there is much more exercise of the upper region of the trunk and arms than Mr. M'Laren admits. The late Mr. Skey devoted considerable attention to the study of muscular action in rowing (*vide* THE LANCET, Oct. 2nd, 1869), and he came to the conclusion that "an important adjuvant of good rowing is seated in the lower extremities, the muscles of which are brought into strong action; but to suppose that the muscles of the thigh and leg play a very prominent part in the act of rowing is a physiological error." A recent writer, Mr. MacMichael, himself a University oar, says: "In the act of dropping the handle of the oar and the turning of the wrist, in the swift motion of the hands forwards (which is so necessary to prevent the handle of the oar catching the knees, as it is liable to do in roughish water if the motion be deferred till after the knees are bent upwards by the forward motion of the body), several muscles of both parts of the arm and the chest are brought continuously into play, and are developed in a corresponding manner." Rowing is an exercise peculiarly fitted for lads—that is, when properly taught, and carried out under proper supervision, because the exercise is continuous and equable, and none of the muscles or joints are exposed to sudden strains or wrenches. It is a pity rowing is not more accessible to the inhabitants of our towns, but wherever it is practicable a boat-club ought to be established.

SMALL-POX IN BOMBAY.

BOMBAY is now suffering from an epidemic of small-pox, the severity of which almost recalls the plague-like devastation caused by this disease in pre-vaccination times. During the first eleven weeks of this year 1443 fatal cases of small-pox occurred in this Eastern city, the weekly numbers increasing steadily from 23 in the first week to 319 in the week ending the 14th of March. The 585 deaths from small-pox returned in the first fourteen days of March were equal to an annual rate of 24 per 1000 persons living, whereas the small-pox rate in London during the two most fatal weeks of the epidemic in 1871-2 was but 4 per 1000. In the Kamateepura district, with a population of about 47,000 persons, 225 small-pox deaths occurred in the eleven weeks, equal to an annual rate of 23 per 1000 throughout the period. The disease appears to have first become severely epidemic in this part of the city. In the whole of the city the annual small-pox rate was equal to 10·6 per 1000 during the eleven weeks; it averaged 8·6 among the Hindoos of different castes, 17·5 among Hindoo outcasts, 15·3 among Moosulmans, 9·0 among Parsees, and 7·1 among Europeans (including those returned as Indo-Europeans), who only number about 10,000 persons. The European population of Bombay appears, therefore, to be suffering severely from the neglect of vaccination among the natives, and it may be presumed that the type of the disease now prevailing in Bombay is of unusual malignancy. The disease has caused some deaths among the seamen of the East India squadron stationed off Bombay, and the *Undaunted* and *Doris* have both been ordered to the Mauritius for change.

DR. BUCKNILL ON TEMPERANCE.

IN a speech at a Permissive Bill meeting at Rugby a few days ago, Dr. Bucknill added his strong and weighty testimony to the disastrous effects of alcohol as a cause of disease, and especially of insanity, not only in the individual but in his children. He pointed out how erroneous is the popular impression which limits the damage caused by alcohol to the drunkard. Many men who never get drunk materially shorten their lives by drink.

The latter part of Dr. Bucknill's speech was devoted to an expression of disapproval of the attempt to treat habitual drunkenness under any circumstances as a disease. To treat it as such is, in his opinion, a great mistake. He opposed any change in the law that would enable doctors to "treat drunkards as poor diseased people, not, as he would deal with them, as vicious people to be repressed and reformed; or to deal with the question as a great social one, upon which the lines of their educational system should be very much directed." "Habitual drunkenness is not a disease, though it causes all manner of diseases; but in itself it is a vice and ought to be treated as a vice."

Such a view involves, we believe, a grave error, to which we regret that Dr. Bucknill lends the weight of his authority.

It is easy to put the matter as an absolute alternative. Drunkenness is either a vice or a disease; it is certainly often not a disease, therefore it is always a vice. The truth is, as we have often pointed out, drunkenness is both a vice and a disease. The only chance of success in dealing with it lies in the recognition of both its phases, in the discrimination of the character of individual cases, and by their appropriate treatment. Dr. Bucknill ignores the wide range of facts which testify that habitual drunkenness is, in a large number of cases, essentially a disease. He condemns institutions for the treatment of dipsomaniacs on the strength of some parodies of such institutions which he inspected in America. A friend had, in an inebriate asylum at Ward Island in New York, visited the rooms of four of the inebriates, every one of whom was able to offer him a choice of spirits. It is absurd to draw from such facts any inference, except of the worthlessness of the statistics of failure which come to us from the other side of the Atlantic. All that Dr. Bucknill urged in favour of education, and the punishment of vicious drinking, we heartily endorse; but we must not, in our hopes for measures still in the far-off future, neglect the means of treatment which may be at once available, and are, for some cases, more appropriate.

THE VESTRY AND THE MEDICAL OFFICER OF HEALTH IN LAMBETH.

THE principle of local self-government in health matters received a severe discouragement when the Lambeth Vestry, on the 6th instant, by a majority of three in a meeting of seventy-three members, passed a resolution calling upon their medical officer of health, Mr. McCormack, to resign. The ground upon which the vestry sues for this divorce may, moreover, be simply described as "incompatability of temper," for no charge of neglect of duty was even suggested. It is, perhaps, more probable that the real offence was a too zealous performance of his duty. The origin of the unsatisfactory relations which now exist between the vestry and the medical officer appears to be due to an almost unprecedented treatment of Mr. McCormack's last annual report by the sanitary committee of the vestry. When the annual report was brought before the vestry, the chairman of the committee announced that he produced two versions of the "medical" portion of the report, one drawn up by the medical officer and one by the committee. The committee had drawn up its version without conferring with the medical officer. The vestry, fairly puzzled, ordered both versions to be printed, an instruction which the committee interpreted by printing their own version in the body of the report, with the signature of the medical officer, whereas the medical officer's report was printed separately. Mr. McCormack naturally objected to accept the committee's report as his own, more especially as he urged that it was inaccurate, but offered to revise his own report if the vestry wished it. The committee failed in an endeavour to induce the vestry to bind the medical officer to adopt and revise their report instead of his own. The matter was referred back to the committee, who subsequently appear to have subjected the medical officer to a course of treatment which it must have been difficult to bear with equanimity. Without intimate knowledge of the ground of the objections made to Mr. McCormack's original report, it is not easy to decide whether he was wise or unwise to consent to revise it with a view to please the vestry, but there can be no two opinions as to the conduct of the health committee in attempting to substitute a report of their own for that of their medical officer of health, and this without any reference to the latter. Those who remember the relations which subsisted between the Lambeth Vestry and the two preceding medical officers of health, Drs. Odling and Puckle, will have less difficulty in apportioning the blame in this unseemly squabble. The vestry is probably aware that it is perfectly optional on the part of Mr. McCormack whether he adopt or ignore the resignation dictated to him; but whether he resign or decide to hold his appointment in spite of his sanitary authority, the discredit attaching to their conduct in the matter will remain the same, and materially strengthen the hands of those who believe in the necessity for further centralisation in sanitary organisation.

THE UNIVERSITIES BOAT RACE.

SURPRISE has been expressed at the deterioration shown by the Oxford crew during their practice on the London water, and it has been generally thought the crew were overtrained previous to their arrival. This we do not think was the case, for the work done on the home water by the Oxford crew this year compared with that of past years was certainly not above the average; whilst on the Thames both the Oxford and Cambridge crews fell short of their usual practice. We think the deterioration was caused rather by nervous anxiety and depression than by overwork. Previous to their arrival, Oxford were favourites at extravagant odds, and the chances of Cambridge were considered hopeless. The disappointment therefore on finding that crew much better than was anticipated, and that their own performance did not come up to the expectation that had been formed of it, must have been great. We know that horses in training are extremely susceptible to external influences, the change of stables, of water, or the absence of a stable companion, often causing the horse to train *off*; we can therefore well understand the effect discouraging reports would have upon a crew. Men who are anxious and worried will quickly fall out of condition because these disturbing influences interfere with the processes by which the nutrition of the muscular and nervous systems is carried on. Under the old plan of training every effort was made to keep the crew as quiet as possible and in ignorance of the progress they were making, and the times of the trials were only known to the "captain" and the "coach"; a little extra praise from the latter being the only encouragement received. The advantage of the plan is obvious; it kept a crew from becoming careless, from counting too much on fast trials, whilst it prevented the demoralisation that bad performances always entail. This year the evil effect of too great publicity was strongly marked, because the disappointment was unusually great. We believe the presidents of rowing clubs would act wisely if they kept from their crews reports likely to unduly elate or depress them.

INDUSTRIAL SCHOOLS.

"WE are very well and very happy, and we cannot be too thankful to the rev. father for his continued kindness to us." This is how the poor children at St. Joseph's Roman Catholic Industrial School, Salford, Manchester, are required to write home to their relatives. Among the proofs of kindness for which they are expected to feel thankful would seem to be such tokens of what the world might call gross neglect as "sore eyes," "vermin," and personal uncleanliness of divers descriptions. It is not necessary to expatiate on the disgraceful state of affairs at this particular establishment. Nothing can extenuate the fault of those who, being responsible for the care of helpless dependants, fail to discharge their obvious duty. Meanwhile, where are the school inspectors? We begin to have misgivings that the business of inspection at asylums and refuges of all kinds is not so efficiently performed as the nature of the function re-

quires. The supervision of work done for the care and comfort of the poor ought on no account to be permitted to drift into mere routine. Running over a list of names, bestowing a cursory glance on a crowd of adults or children, sane or insane, is not *inspecting* in the true and only worthy sense of the word. Unfortunately, there is too great reason to fear that much of the inspection which constitutes the sole check on managers of public and some private institutions is nothing more than a mere formal verification of previously formed opinions. The inspector who enters a school or asylum with the anticipation that all will be found as it should be generally discovers little of which to complain. We do not believe commissioners and inspectors are either careless or incompetent, they are only prejudiced. They see things, not as they *are*, but through a rose- or yellow-coloured medium as the wish or the whim takes them. Probably the inspectors who have from time to time visited this model school at Salford, started with the presumption that inmates of an institution under the guardianship of learned and reverend fathers ought to be well and thoroughly cared for. Impressed with this not unreasonable idea they did not deem it necessary to inquire too closely into such small details as personal cleanliness, health, and regimen. It escaped the notice of inspectors imbued with this comforting persuasion that the children confided to these reverend fathers were infested with vermin, that they were manifestly unhealthy, and, in short, that they were the victims of systematic mismanagement and neglect. The managers of the Industrial School at Salford are probably not offenders beyond all comparison with the managers of schools and kindred institutions elsewhere. It is their misfortune that they have been exposed. If society does not approve the state of affairs at these schools, the remedy, the only remedy, is to improve the character of inspectorial work generally. The condition of matters disclosed could not clearly have continued a week if the general inspectors had done their duty as public opinion requires that such duty should be done. The *misunderstanding* is serious and, we fear, widespread: the consequences call for redress.

INQUEST AT SLOUGH.

AN inquest was lately held at Slough on the body of a man, aged sixty, who died three days after a fall on the top of his head, death being preceded for twenty-four hours by violent delirium. The history of the case presents no uncommon features, but it has received much local attention from the fact that the man was taken to the Windsor Infirmary the day before, and refused admission on account of his violent condition and because there was no male attendant in whose charge he could be placed. Want of space was alleged at first as a reason for the refusal to take him in, but it afterwards transpired that there was an untenanted room in which such cases were sometimes treated. The man accordingly had to be carted back to Slough, where he died next day. The jury in their verdict expressed an opinion that the surgeon at Slough would have done better to have sent the case at once to the workhouse infirmary there, and, further, that the house-surgeon to the Windsor Infirmary ought to have admitted the patient when brought to the institution. On each of these points their opinion is certainly correct. It was undoubtedly unwise to send a patient in such a state miles across country to a small infirmary without first ascertaining whether he could be admitted, especially when a more suitable place was at hand. On the other hand, there ought unquestionably to be in every provincial infirmary due convenience for the treatment of a case of delirium from head injury. It is ridiculous to describe a patient who has had a recent fall on his head, and has only been delirious a few hours, as "fit for a lunatic asylum." A strait-waistcoat or tied sheet was needed rather than a skilled male attendant. In such cases of sudden emergency where male assistance is needed the help of the police ought to be available.

THE BRITISH MEDICAL ASSOCIATION.

A MEETING of some medical men resident in Sheffield and the neighbourhood was held in the Medical School, on Saturday, April 9th, "to consider the propriety of inviting the British Medical Association to visit Sheffield in August next, and thus to relieve the Association of the difficulty which has arisen from the death of the president elect, Sir John Cordy Burrows, of Brighton." The meeting was not a spontaneous gathering of the local practitioners, but was summoned by the local members of the Council of the Yorkshire branch of the Association. There were present twenty-eight gentlemen, of whom some nine were from neighbouring districts, the remainder being resident in Sheffield. After a resolution had been proposed in accordance with the objects of the meeting, it was suggested that the small number present might be said not to represent Sheffield opinion, and that, considering the indifference exhibited on the subject (only twenty-eight being present out of two hundred and fifty invited, and only two having written to express their opinions), it would be well to adjourn. However, the resolution was carried, and a deputation appointed to wait on the Council of the Association. Some present seemed to think it would be better to wait until it was ascertained whether Liverpool was disposed to support the invitation it gave to the Association at the time when that from Brighton was accepted. Dr. Bartolomé was elected president, in prospect of the acceptance of the invitation, and a committee was appointed.

SOUTH SHIELDS CORPORATION AND ITS MEDICAL OFFICER OF HEALTH.

THE Corporation of South Shields have just been saved by a majority from doing a shabby, not to say perfectly unjust, action. Its medical officer (Mr. J. Spear) and the town surveyor had been ordered by the Council to visit various towns to report on their slaughter-house arrangements. They visited about nine different towns, and of course presented a bill of expenses, amounting to £27 19s. 2d., which seems to us very moderate. But one of the councillors thought it so immoderate that he proposed that it should not be paid. We should probably not have noticed the proposal had it not been that it found a supporter in one of the medical members of the Council, who so far forgot what was due to himself and his profession as to say "he thought the bill a little bit of a swindle; if he happened to go away he had to pay his own expenses." Mr. Spear's reports have already attracted the attention of the medical inspectors of the Local Government Board, and we hope for the sake of South Shields that the gentleman will see his way to express his regret for words concerning an able officer of health which came strangely from a medical man.

THE URBAN AND SUBURBAN MILK-CAN.

AN instructive case was tried last Saturday at Bath, in which a milkman admitted that he carried two cans, the one containing pure milk, which he distributed in the suburbs, where there was a public analyst; the other a milk adulterated with at least 20 per cent. of water, which was disposed of in the city, because there was no such official there. It may be encouraging for intending visitors to learn that the man is still pursuing his profitable trade, and will doubtless continue to do so till some public-spirited

person undertakes to prove the adulteration, and thus perform the duties the local authorities refuse to carry out for the protection of the community. Only a few weeks ago we had to notice a serious outbreak of enteric fever at Bath, which was clearly traced to milk contaminated with specifically infected water. If the appointment of a county analyst is sufficient to ensure for the suburbs of Bath a supply of pure milk, it is a disgrace that the large and important town should be left without protection. Bath depends much for its prosperity on its visitors, but the apathy and parsimony of the local authorities have allowed it to fall behind other health resorts in various matters. The persistent refusal to appoint a public analyst is an instance of their short-sighted policy. We may be sure that if they neglect such an important particular, there are many minor points concerning the health and welfare of the town which are also viewed with indifference. In the meantime it is too bad that the inhabitants of Bath should have fraudulent commodities foisted on to them because there is no restraining influence to prevent their sale. Visitors of a scientific turn of mind might spend a profitable week at Bath in investigating the composition of certain samples of "prime Dorset butter" to be found in that city, and in tracing the sources of the various contaminations that are to be found in the milk supply.

INNERVATION OF THE THYROID GLAND.

M. POINCARÉ, in the just published part (p. v., 1875) of *Robin's Journal de l'Anatomie*, states that he has been struck with the great richness of this gland in nervous filaments of all sizes. This is the more curious since the gland presents no remarkable indications either of sensibility or motility. No doubt the gland contains a large number of vessels, which require, consequently, many vaso-motor fibres, but the nervous supply is out of proportion to what may be supposed requisite for this purpose, and M. Poincaré thinks this peculiarity accounts in some measure for the close relationship known to exist between the thyroid gland and the generative organs, and believes that many of them are of a sensory nature. The nerves form close plexuses surrounding small islets of the substance of the gland, and the branches passing to and from the gland stand (as he expresses it) in the relation of telegraphic cables between the thyroidean colony and the metropolitan cerebro-spinal axis. To continue the simile, the colony has itself an autonomous system of telegraphy, the stations being represented by numerous microscopic ganglia, with connecting branches which do not pass outside the gland. The best means of examining the nerves of the gland he finds to be, not hardening agents such as osmic acid, but softening and disintegrating agents, and he has obtained good results from maceration in water acidulated with acetic acid, and slightly coloured with fuchsine.

HOW A BEGGARLY MEDICAL SALARY IS PERPETUATED.

A VERY interesting discussion in the Rotherham Board of Guardians, on the propriety of raising the salary of Mr. Smith, the medical officer of Rawmarsh, in response to an application from him, is reported in the *Rotherham and Masbro Advertiser*. Mr. Smith's salary was not defended by any guardian, but those who voted against its increase did so on the ground that another gentleman had offered to do Mr. Smith's work for his present salary. The salary was £20 a year. In the past year he had given 2437 attendances and medicines, which allows 2*d.* for each attendance. If the gentleman has not been misrepresented, he is not to be envied in his reflections on this matter. He has prevented Mr. Smith getting an increase of remuneration which would certainly have been given to him but for the impression that another professional man was ready to give his attendance and medicines for twopence. We are pained to think that medical men can be found to keep down remuneration for medical work. But this does not excuse the guardians, who must be blamed for a salary altogether disproportionate to the services rendered, and to the salaries of the medical officers in the same union.

THE PLAGUE.

THE latest news from Mesopotamia is not altogether reassuring as to the progress of plague there. Although no considerable development of the disease has occurred either in Hillah or Bagdad, the malady still continues in both cities, and shows as yet no signs of dying out. Local opinion is not satisfied that the period has passed when a great outbreak might occur, although there had been no indications, to the latest news, either of the diffusiveness or the fatality which characterised the disease during its prevalence on the Lower Euphrates in the early months of 1874 and 1875. The Ottoman Government has taken active measures in Bagdad to meet any extension of the malady, by building huts for isolation of cases outside the city boundaries and organising a medical staff for the purpose of treatment, disinfection, &c. Since the recognition of plague at Hillah in February to the close of March, upwards of 100 cases have been recorded in that town, half fatal; and during the first ten days after its appearance in Bagdad about 150 cases were recorded, of which 60 died. The number of cases occurring daily in Hillah in the last week of March averaged 20 a day; in Bagdad, 24.

THE GENERAL MEDICAL COUNCIL.

SURELY it is not unreasonable to be curious as to the successor to Dr. Parkes. It would be affectation to pretend indifference to such an appointment, or to believe that it had not been already decided. The profession awaits the announcement with great anxiety, in no spirit of criticism, but with a desire to hear that a most conspicuous blank in the Council has been worthily filled.

Summonses have just been issued for the annual meeting of the Council, which is to be held on Wednesday, May 24th. The Executive Committee will, as usual, assemble the day previous in order to arrange the business of the Council.

ST. ANDREWS GRADUATES' ASSOCIATION AND THE UNIVERSITY.

AT the last meeting of the General Council of the University of St. Andrews, Principals Tulloch and Shairp and Professors Swan and Pettigrew were added to the London Committee of the General Council, which was appointed in 1873 "to watch over the interests of the University in the event of any action either in Parliament or otherwise." The convener is Dr. Richardson, and he is also empowered to "assume as members of the said Committee those members of the General Council who, at the time being, are members of the Council of the St. Andrews Graduates' Association."

POOR-LAW MEDICAL RELIEF IN SCOTLAND.

WE are pleased to announce that the Faculty of Physicians and Surgeons of Glasgow have resolved to petition the House of Commons in favour of an amendment of Scotch Poor-law Medical Relief, following as the text of their petition pretty closely that suggested by Dr. Jos. Rogers, and published by us in our issue of the 25th March.

We trust that the Medical Corporations of Aberdeen, Edinburgh, and St. Andrews will follow the example thus set by Glasgow.

THE reports of the Inspectors of Factories for the half-year ending October 31st, 1875, issued within the last few days, contain several interesting returns. Mr. A. Redgrave having had his attention called to the subject of lead poisoning and to the condition of persons employed in white-lead works, requested the metropolitan sub-inspectors to make special investigations into the matter. The results of the inquiries showed that there is considerable danger to health in white-lead works; that in works in which full precautions are provided, and their use insisted upon, ill-health and disease are reduced to a minimum, and that sufficient effort is not made by manufacturers to protect their workmen. Mr. Redgrave then gives some rules which he thinks should be carried out in white-lead works. Mr. Robert Baker has a report on "The Deterioration of the Physique of Factory Children." There is little doubt that physical degeneracy goes on in parts of the country. Mr. Baker advises a persistent medical supervision of all factories in which numbers of young persons and children are employed. Mr. Baker has also a report on "Our Canal Population," attached to which is an excellent map of inland navigation. We shall probably deal with these reports at greater length on a future occasion.

THE Registrar-General, in his last Weekly Return, calls attention to the fact that the cause of each of the 300 deaths registered in East London during the week ending 15th inst. was certified either by a registered medical practitioner or by the coroner. In South London, however, the cause of 11, or 2·5 per cent., of the 441 deaths was uncertified. These 11 deaths included 6 of infants one year of age, and 4 of adults. The large percentage of inquest cases in East London not only secures to the death-register more reliable information as to the cause of death, but has reduced the proportion of uncertified deaths to a minimum. Until some more simple form of inquiry is instituted to meet cases of uncertified causes of death in which there is no suspicion of violence, the holding of more inquest cases in South London is urgently called for, more especially as a protection to infant life, which is often sacrificed to the neglect of medical advice and to the ignorance of unqualified practitioners.

WE desire again to call attention to the Obstetrical Society Conversazione, to be held at the Royal College of Physicians on the 10th of May. We trust all those having in their possession portraits or records of celebrated medical men, as well as those of ancient obstetrical institutions, will communicate without delay either with the secretaries of the Society, 51, Berners-street, or with Dr. Grigg, 6, Curzon-street, Mayfair, as it is intended to send round a catalogue of the various contributions before the 30th inst.

ADVICES from Rio Janeiro of March 24th contain accounts of the epidemic of yellow fever now raging in Brazil. The deaths from the disease range from fifty to sixty daily. The crews of ships in the port appear to suffer less than they did in 1873. All immigrants on arrival are at once sent on board the receiving transport and conveyed to the mountains by night. Fever hospitals have been established by the Government in out-lying districts, for persons of limited means.

HOSPITAL Sunday and Saturday collections have just been held in Liverpool with very satisfactory results. The committee of the funds have been able to distribute a sum of £9600 among the medical charities of the town, the Royal Infirmary receiving the larger share of £2976. We observe a grant of £192 was made to the "Homœopathic Dispensary."

PROFESSOR TRAUBE of Berlin, who died on the 11th inst., was born in 1818, in Silesia, and studied medicine at the Universities of Breslau and Berlin. After taking his degree he went to Prague, Vienna, and Paris, where he studied specially methods of physical examination of the chest. Returning to Berlin, he soon became an eminent specialist for heart and lung diseases. As a member of the Mosaic confession, it was not till after the revolution of 1848 that he was admitted to the Charité Hospital as clinical assistant to the celebrated Schoenlein. He was the first civilian resident physician in the Charité, the other places being filled, as the majority of them are at present, by doctors of the army. In 1853 Traube became a clinical teacher, and acquired as such a high reputation. Virchow, who was associated with him by the similarity of their aims and studies no less than by personal friendship, has written his necrology in feeling expressions in the last number of the *Klin. Wochenschrift*. The medical faculty of the Berlin University has lost during the last twelve years the following ten members: Casper, Remak, Griesinger, Graefe, Mitscherlich, Romberg, Schulz-Schulzenstein, Tuengren, Martin, Traube.

AFTER a period of unusual quiescence, small-pox shows increased prevalence in London. During the week ending 15th, four fatal cases were registered within the metropolis, a higher number than in any previous week since January 1875. One of the four was of an unvaccinated child, aged three years, in the Stockwell Small-pox Hospital, to which it had been admitted from Lambeth; two other cases were of children, also aged three years, both "not stated" as to vaccination, occurring in Bermondsey and Stockwell; the fourth case occurred in the Islington Small-pox Hospital, and was of an adult female, who only bore "bad cicatrices" as evidence of having been vaccinated in infancy. It is to be much regretted that in so many certificates of death from small-pox, the certifying practitioner omits to state whether the deceased had or had not been vaccinated.

A LETTER from the managers of the Poplar and Stepney Sick Asylum, read at a late meeting of the Board of Guardians of the former parish, contained a statement which, on the first blush, appears somewhat remarkable. It was to the effect that during the last month no fewer than ten persons had died within sixty-five hours of admission to the asylum. In one instance death occurred five minutes after admission; in another, four hours had elapsed; and in another, six hours. Of course the circumstances may be altogether exceptional, and capable of easy explanation, which will no doubt be forthcoming from the medical officers of the Union, to whom the letter was referred.

SIR WILLIAM ROBERT WILDE, Surgeon-Oculist in Ordinary to Her Majesty in Ireland, died at Dublin on Wednesday. Sir William established the first hospital for ophthalmic disease in Ireland, about forty years ago, at his own expense, and has since 1841 been a Census Commissioner. He was the author of numerous pamphlets on medical, statistical, and other subjects, and his work on "Aural Surgery" has been translated into several languages. He was knighted by the late Earl of Carlisle, Lord Lieutenant of Ireland, in 1848.

THE fourth annual report of the sanitary condition of Tenby has just been issued by Mr. Griffith Lock, M.A.Cantab., the medical officer of health for the town. It is brief, and presents no special feature of interest. The health of this very pretty Welsh watering-place appears to be good, although, Mr. Lock says, "there are several parts of the town which require draining, and there is no ventilation to any of the sewers."

THE Uxbridge Rural Sanitary Authority, in a report presented to them by Mr. Roberts, medical officer of health, are urged not to permit any house to be erected in the district unless satisfied by inspection of the plans that the system of drainage will be good. A stricter supervision over buildings about to be erected would, without doubt, greatly tend to the salubrity of some of our suburbs. The plan suggested by Mr. Roberts could be carried out without much difficulty.

IT is proposed by members of the profession in Dublin to present Dr. Maurice Corr, to whom the Irish Poor-law Medical Service owes so much, with a substantial testimonial. An influential committee has been appointed, including Professor Colles, Dr. Hayden, Dr. Mapother, the Rev. Prof. Haughton, &c., who are now prepared to receive subscriptions.

THE inaugural meeting of the Association of Surgeons practising Dental Surgery will take place at 11, Chandos-street, W., on Wednesday, April 26th, at 8.30 P.M. The Chairman will give an address, which will be followed by a discussion upon the manifestations of syphilis exhibited in the development of the teeth.

ON the 13th inst., Dr. E. H. Sieveking, Physician Extraordinary to the Queen, was elected an Examiner in Medicine at the Royal College of Surgeons of England, in the vacancy occasioned by the resignation of Dr. Wilks, who has so admirably performed the duties since the establishment of the chair in 1868.

A NEW medical weekly has just been published in the German language at St. Petersburg, instead of the former bimonthly journal. The new periodical has a rather large programme, and promises to publish all laws and decrees relating to medical and sanitary affairs in the Russian empire.

MESSRS. BARRAUD and JERRARD, Gloucester-place, Portman-square, have forwarded to us a photograph of the late Mr. Campbell De Morgan, taken last month, which they say is the only one he ever sat for. It is a very faithful likeness.

CAPTAIN DOUGLAS GALTON will read a paper on "The Sanitary Progress of India," at the Society for the Encouragement of Arts, &c., John-street, Adelphi, this (Friday) evening.

MEDICAL DEFENCE ASSOCIATION.

A MEETING of the Council of the Medical Defence Association was held at the residence of the President, Dr. Richardson, F.R.S., on the 7th inst. A letter was read from a member residing at Over Darwen, in Lancashire, directing attention to a case in which an unqualified person had attended a twin labour, but had allowed one child to remain unborn, and the patient died on the third day after the birth of the first child. The formation of a branch of the Association in that part of Lancashire was suggested. Complaints were also received from two provincial practitioners respecting persons who are practising without legal qualifications. The secretary was requested to communicate with the Council of the Royal College of Surgeons, and ask whether they will allow the Association to prosecute in such cases under the powers contained in the College Charter. A letter was read from the secretary of the West Cornwall Branch Association reporting the recovery of a penalty of £20 from an unqualified practitioner at Redruth. Letters were read from the honorary secretaries of the Coventry Medico-Ethical Society, and the Devon and Exeter Medico-Chirurgical Society, expressing the desire of the members of the above bodies to become connected with the Defence Association.

It having been reported that a person, whose name it is desirable not to mention at present, is practising medicine without legal qualification in the metropolis, the solicitors to the Association were instructed to prepare the evidence with a view to prosecution under the Apothecaries Act. A handbill said to have been issued by a person whose name appears in the Medical Directory, and who practises homœopathy, was submitted to the notice of the Council, but it was decided that the matter was one that scarcely came within the province of the Association.

Correspondence.

"Audi alteram partem."

MR. HUTCHINSON'S "CHEIRO-POMPHOLYX."

To the Editor of THE LANCET.

SIR,—Dr. Tilbury Fox is quite right in thinking that I owe him some apology for not having read his articles on Dysidrosis, and further for not having referred to them in the description of my plate of "cheiro-pompholyx." I had quite intended both to read the paper and append to my description a footnote of reference to it, but, being very much hurried when my proofs were going through the press, I forgot to do so. I am very sorry for it, not only because the omission may have caused me to do Dr. Fox's labours in dermatology some injustice, but because he had written to me courteously asking me to read his paper, and I had expressed my intention to do so. Here, however, my apology must end; and if Dr. Fox supposes, or has by his citation of parallel passages led anyone else to suppose, that I may have in any way availed myself of his work, I repudiate the accusation with scorn. I had never until this week read one word of what he has written on the subject, and nearly all that I have said in the description of my plate had been familiar knowledge to me many years before 1873, the date of his paper. Let me say further, that if Dr. Fox had given all the dates, instead of only some of them, I need not have troubled you with this reply.

Dr. Fox writes that my illustration was taken from a case which he also had seen, but he does not add the important fact that the patient in question had been more than fifteen years under my observation before he saw her. The portrait was taken in 1864 as a remarkable example of the disease, and since then I have used it in public repeatedly for lectures, and described all the features of the malady which it illustrates. I used to mention it as a peculiar bullous eruption on the hands and feet, disappearing spontaneously, and evidently of neurotic origin. In 1871 Dr. Fox, for the first time, saw the same patient, and in 1873 he published his description of dysidrosis. Now, I cannot but think that, remembering these facts, Dr. Fox might have spared the greater part of his communication, and that he certainly ought not to have penned such a sentence as the following: "I will put, side by side, Mr. Hutchinson's description of April, 1876, and my description of Jan. 1873 (Skin Disease), concerning the main characters of the disease." He knew quite well, I repeat, that what he was about to quote from me was simply the account of a case the portrait of which was taken some years before his book was published. When we had seen the same patient, and both of us carefully studied the disease, can he for a moment wonder that our descriptions should be similar? That I had taken great interest in the malady he had every reason to know, for I had sent an artist down to Nottingham to take the portrait which I have just published. Let me repeat that this was in 1864, and that Dr. Fox did not publish anything about it till 1873. Not only had I observed this case, but many others; and I had given several lectures on the malady both at the London Hospital and at Blackfriars. My portrait had also been exhibited some years ago at one of the annual museums of the British Medical Association—I think at Oxford.

Now I do not for one moment accuse Dr. Fox of having

plagiarised from me, although the facts shew that it migh have been possible. I know that he is quite incapable of such an act, and I have not the least doubt that he wrote about "Dysidrosis" quite in ignorance that I had long before been describing publicly, if not in print, a "peculiar neurotic bullous eruption on the hands," which is, I now find, identical with part of what he wished to include. It is another of the many instances in which two independent observers, looking at the same facts, come to nearly the same conclusions, and describe them in nearly the same words. Dr. Fox will, on reflection, I feel sure, admit that inasmuch as the case had been nine for ten years before he saw it, studied with the utmost care, and a portrait of it taken, I had a full right to publish it when I liked with my own description, and, if I cared to be so foolishly venturesome, with a new-coined name. I have not written a paper on "Dysidrosis." I have simply published a portrait which had been long in my collection, with notes of the case, which was taken many years ago, appending a few additional remarks on the general subject. That it is "dysidrosis," or has anything to do with "dysidrosis," I do not in the least believe, and it is clear that I could not have used any name implying that I did.

Dr. Fox seems to think that the term "sago-grain spot" is in some way his property, and could only have been borrowed from him. It has been in every-day use, let me assure him, for many years, and not only in connexion with the skin, but also with the eye. The "sago-grain spot" is, as I have said in my description, very common indeed. I am sure I have been quite familiar with it for twenty years past, and I do not think that it is peculiar to this disease. The point which is really original to Dr. Fox is his supposed recognition of the nature of the malady as a "dysidrosis" (difficulty in sweating, or obstruction of sweat-glands). I certainly should have been guilty of what he seems to hint at had I borrowed this explanation. But I have not, and, as yet, I do not adopt the hypothesis, and much prefer a name which recognises clinical peculiarities, but does not imply any anatomical speculation. By conversation with mutual friends, and, I think, with Dr. Fox himself, I was well aware of his hypothesis on this matter, and had thought it over. Since his article of last week, I have carefully read his description in his book. I am obliged to say now, what I should have been quite willing, unless thus challenged, to have left unsaid, that I do not think that Dr. Fox has in the least proved his point. If, on further investigation, I change my opinion, he may rely upon it that I will say so, but for the present I cannot but hold that he does not produce the least fragment of evidence in favour of his assertion that cases of recurrent bullous eruption on the hands of nervous persons have anything to do with obstruction of sweat-glands. He asserts it, but nothing more. The hypothesis seems to me most improbable, and I ask anyone interested in the question to look at my portrait, and read my case-narrative, and Dr. Fox's chapter on dysidrosis, and judge for himself.

The remarkable features in cases such as those for which I have proposed the name "cheiro-pompholyx," are that the bullæ formed are often very large, and are usually preceded by nervous symptoms, that they are always symmetrical, and usually show a tendency to rapid and wholly spontaneous cure. In many respects they resemble herpes, as seen on the lips and prepuce, but the anatomical characters of the vesicles are dissimilar. In those liable to the disease repeated recurrences take place. Now that Dr. Fox's description of "dysidrosis" should, as he has shown by his quotations, take cognisance of most of these points, is not surprising, seeing that he had ploughed with my heifer, and had, in part at least, described what he saw in a case which I had been observing for ten years previously, and which was, I have little doubt, by far the most marked and important example of the malady that either he or I have ever seen. But he does not mention them all; thus he omits, I think wholly, the most important, the tendency to periodic recurrence, and he uses terms which would imply that it sometimes affects one hand only; and lastly, he says of the subjects of it, "they always perspire too freely." This last fact would certainly seem to connect the malady with the sweat-glands, but it so happens that in my case the patient did not perspire much, and could never find the weather hot enough. Dr. Fox complains that I have said in my description, "I am not sure that any correct clinical description of the disease has been given." I admit that this was only a guess, since I had not then read his papers, but I must add that now that I have read them I am prepared to put the doubt more strongly.

If Dr. Fox should ever be able to prove his conjecture as to the sweat-glands being concerned in what I have named "cheiro-pompholyx," he will have made an important discovery, and justified his own name for the malady. That, however, *is*, I assert, the only point in which he can claim originality, for in all the others, and in more than all, I had anticipated him by several years. May I ask him to remark that I say this only in self-defence. I would have been quite silent had he not attacked me.

I am, Sir, yours, &c.,

April 18th, 1876. JONATHAN HUTCHINSON.

P.S.—Since this letter was written I have found the notes of a lecture delivered at the London Hospital in 1871. I will, with your permission, print these fragmentary notes verbatim in next week's LANCET, and by comparing them with Dr. Fox's quotations it will be seen that I have been indebted to his paper of 1873 for nothing, not even for a "sago-grain."

TREATMENT OF ACUTE RHEUMATISM BY SALICIN.

To the Editor of THE LANCET.

SIR,—I beg to express my regret that I did not give greater prominence to Dr. Maclagan's treatment of acute rheumatism by salicin, but the remarks I added to Messrs. Gawith and Sworder's reports of the cases under my care treated by salicylic acid were already written when Dr. Maclagan's paper came under my notice, and the reference to it was hastily inserted at the last moment. It should be understood also that the communication respecting my cases waited for some time for publication after being forwarded.

Dr. Maclagan's treatment by salicin is clearly original, and I shall be very glad if he can establish priority. It is, perhaps, some compensation for my imperfect recognition of the value and importance of his communication that I am now able to say that H. Senator, in a short paper suggested by it (*Centralbl. f. Med. Wissen.*, Berlin, No. 14, 1876, of which he has kindly sent me a copy), gives reasons for expecting that salicin will be superior in efficacy to salicylic acid, as well as cheaper and more easy of administration, salicin being split up in the blood and yielding salicylic acid in a nascent and more energetic condition.

I remain, Sir, your most obedient servant,

W. H. BROADBENT.

Seymour-street, Portman-square, April 9th, 1876.

HYDROPHOBIA.

To the Editor of THE LANCET.

SIR,—From Dr. Muscroft's paper in your impression of to-day, it appears that hydrophobia may supervene after the bite of a dog whether the animal be rabid or not. Taking this as an axiom, the author concludes that it is necessary in all cases of dog-bite to practise "free cauterisation." It seems to me that, whether the animal be rabid or not, cauterisation is of no avail, and that the practice should be abolished from surgery.

There are two good reasons for discontinuing the practice. 1st. It does no good. The caustic is never, or hardly ever, at hand at the time the bite is inflicted, and to cauterise after even five minutes can be of no avail. As morphia is almost immediately absorbed after a hypodermic injection and manifests its presence in the system by its action on the pupil within a minute of administration, so it is evident that the virus received from the dog's saliva will be absorbed equally quickly. Theoretically, therefore, the treatment is of no avail; practically we find that many cases of hydrophobia have had the antecedent bite cauterised. Of seven cases of this disease which have come under my notice, nitrate of silver had been applied in three. 2nd. Caustic often does harm, as witness the cases of diffuse cellulitis and erysipelas which are too often met with from

its free application. When these evil results do not occur it frequently happens that the simple wound, which would have healed in two or three days, is converted into a large sloughy sore which is only cured in the same number of weeks.

Let us then leave this supposed remedy to quacks and empirics, and try to devise a more efficacious preventive for this dire disease.

I am, Sir, your obedient servant,

ARTHUR FERGUSSON MCGILL, F.R.C.S.

Leeds, April 15th, 1876.

THE TREATMENT OF ACUTE ORCHITIS.

To the Editor of THE LANCET.

SIR,—After an extensive experience both in hospital and private practice, I have abandoned the employment of ice, poultices, punctures, leeches, &c., in the treatment of acute orchitis, in favour of the following simple plan, which in my hands has proved pre-eminently successful:—

By means of an ordinary hypodermic syringe, inject beneath the tunica vaginalis from one-sixth to one-quarter of a grain of morphia with one-hundredth of a grain of atropia in solution; and then strap the organ firmly with adhesive plaster. Place the patient upon his back; elevate the pelvis; support the testicle; and administer twenty grains of the bromide of potassium, fifteen drops of the tincture of gelsiminum sempervirens, and a drachm of the tincture or fluid extract of ergot, in half an ounce of cinnamon-water, every third hour.

Repeat the hypodermic injection of the morphia at intervals of eight hours, if necessary, until a grain has been administered; and readjust the adhesive plaster as the swelling and sensitiveness diminish.

In a large majority of cases a decided improvement will manifest itself within three or four hours, but should no amelioration ensue discontinue the hypodermic injections, and supplement the treatment by the application of a narrow blister on either thigh, immediately over the femoral vessels.

I am, Sir, your obedient servant,

EDWARD WARREN, M.D.,
Late Chief Surgeon, Egyptian Army.

Paris, April, 1876.

BIRMINGHAM.

(From our own Correspondent.)

THE district of Birmingham through which new broad streets are to be made is at present densely inhabited; many of the houses therein are unfit for human habitation. Zymotic diseases prevail, and thence ensue death and loss of health. To say nothing of other sanitary defects, such as want of light, air, and ventilation, the "unhealthy area," condemned by Dr. Hill, fully answers the description given of such a district in the Artisans' Dwellings Act, and nothing less than a reconstruction and remodelling of the entire area will render it healthful.

The first amount paid in to the treasurer of the Hospital Saturday movement was £2640 12s., being £140 less than the amount paid in on Hospital Saturday last year. Many other contributions may, however, yet be forthcoming.

The sanitary committee of the Town Council is in future to be called the "health committee." Dr. Alfred Hill will have to give his entire services to the Corporation as medical officer of health and public analyst, and will not even be able to retain the post of Professor of Chemistry at Queen's College, which he has held with so much distinction for many years.

The Coroner has called the attention of the Council to the want of a public mortuary, and the Mayor has promised that the subject shall be considered shortly. It is time something was done, when we hear from the Coroner that the corpse is generally found "lying on the ground (partially covered with old sacks or rags) exposed to the gaze of curious frequenters of the premises, and to the ravages of rats and other vermin."

The Artisans and Labourers' Dwellings Act, 1875, is likely to be put in operation at Wolverhampton. Mr. Love, the medical officer of health, has indicated an area, extending over a space of 11¾ acres, and consisting of 666 houses as "unhealthy." Much of the property is said to be unfit for human habitation, and so dilapidated as to be a mere receptacle for filth and offal. No doubt the Wolverhampton Town Council will see the wisdom of at once putting the Act into operation; they have already done good service in taking the water-supply into their own hands and making it good and ample.

PARIS.

(From our own Correspondent.)

THE MAN WITH THE FORK.

IN several preceding letters, and as circumstances took place, I have acquainted your readers with the particulars of the interesting case known to the Paris public as *L'Homme à la Fourchette*, or "The Man with the Fork." I now refer to it again, as a most important operation—that of gastrotomy—has just been performed upon the man by Dr. Léon Labbé, with excellent results, up, at least, to the present.

If I am not mistaken, it was about a year and a half ago that the man, an *employé* in one of the large dry goods establishments of Paris (le Printemps), swallowed a gilt fork whilst amusing himself with the other clerks at breakfast, and showing his skill at introducing a whole fork into his gullet. The fork suddenly slipped through his fingers, and remained sticking in the œsophagus. A medical man was called in, but was unable, though he could perceive just the end of the fork, to extract it. Finally, it found its way into the stomach.

The man was taken into Dr. Labbé's wards at La Charité, where I (as, indeed, almost all the medical men of Paris) visited him. The fork was to be distinguished, or, rather, felt, lying lengthways in the stomach. Some short trials were made of various means for extracting the instrument upwards; but Dr. Labbé soon renounced all these attempts as useless, and as possibly irritating and mischievous, and the patient was sent into the country to spend some time with his friends.

He got on pretty well, with slight symptoms of indigestion, and after some time returned to Paris, where he has been staying since. His general condition was satisfactory, but from time to time various local symptoms of inflammation occurred, when blisters and other applications and remedies had to be used.

Finally, about two months ago, Dr. Labbé thought the proper time was come to attempt gastrotomy. Accordingly applications of caustic were made to ensure adhesion between the organ and the skin, and the position of the fork, as indeed every other circumstance, seemed very favourable. Unfortunately the patient had an attack of illness, and the operation had to be postponed. At last it was performed, about a week ago.

The fork has been extracted, but it has not been without great difficulty. The operation proved a most arduous and anxious one. Notwithstanding the attempts which had been made to secure adhesion between the stomach and the abdominal walls by successive applications of caustics, the peritoneal cavity had to be opened, and the operation was accompanied by all sorts of turns and risks. I will not insist further in this letter on the particulars, as Dr. Léon Labbé has promised me a full account of the case, which I shall be glad to send to THE LANCET. At present the patient is doing well. He endured the operation very nicely, and no bad consequence has taken place. It is to be hoped that he will make a good recovery. From the extraordinary publicity given to the case by all the daily papers, it may be said that all Paris is interested in the fate of *l' homme à la fourchette*.

DEATH OF BALARD.

Balard, the famous chemist and the discoverer of bromine, has recently died at the age of 73. Balard was Professor of Chemistry at the Collége de France, a Member of the Institute, and a Knight Commander of the Legion of Honour. He had attained the highest scientific post of his country,

and received all the honours which in France are conferred on eminent men of science.

He had had hard times, however, in his early career. He began life at Montpellier (where he was born) under difficult circumstances. At the age of about twenty-four, in 1826, whilst searching for traces of iodine in some specimens from a salt-marsh, he was able to isolate a new substance—bromine. At that time he was a modest student, living on the last floor of an old hotel in Montpellier.

Balard was successively nominated as chemist, then professor, at the School of Pharmacy and Faculty of Sciences at Montpellier. On the death of Thénard, the great chemist, he was called to Paris to take the chair of Chemistry left vacant at the Academy of Sciences.

He was universally liked on account of his amiable qualities and his constant obligingness to all who cultivated science.

NOMINATION OF PROFESSORS AT THE SCHOOL OF MEDICINE.

The Minister of Public Instruction has ratified the choice made by the Professors of the School of two new Professors to fill the chairs of Internal Pathology and History of Medicine, which were left vacant by the promotion of Dr. Hardy to the clinical chair at Hôpital Necker and the death of the regretted Lorain. Dr. Potain has therefore been officially appointed to the chair of Internal Pathology and Dr. Parrot to that of History of Medicine.

The General Association of Medical Men in France will hold its annual meeting here on Sunday next. It is expected that it will be a very full one, and that a great many members from the provinces will attend. The meeting will not include any scientific debates or work. It will be strictly a business meeting, where the prospects of the Association will be discussed and any measures of reform proposed. It will end, as usual, in a public dinner, to be given at the Grand Hotel.

A law regulating the distribution of medical assistance to the poor in the country districts has just been laid on the table of the National Assembly by the Minister of Public Instruction, M. Waddington.

Dr. Brown-Séquard has been nominated Professor of Physiology in the new Faculty of Medicine of Geneva. The Council of State made some other nominations at the same time, and appointed Dr. d'Espine, Professor of Internal Pathology; Dr. Prevost, Professor of Therapeutics; Dr. Viellet, Professor of Clinical Medicine; and Dr. Gosse, Professor of Forensic Medicine.

Paris, April 17th, 1876.

Obituary.

CAMPBELL DE MORGAN, F.R.S.

MR. DE MORGAN, the senior surgeon of the Middlesex Hospital, whose death we reported last week, was the youngest of the three sons of Colonel De Morgan, of the Indian army. He was born at Clovelly, near Bideford, in the year 1811, and his father died during his childhood, leaving his widow, a clever woman, with small means to maintain and educate his children. The elder brother, Augustus De Morgan, the well-known mathematician, was Professor of Mathematics at University College, and died in 1871. Campbell De Morgan commenced his medical career as a student at University College, and afterwards became house-surgeon to the Middlesex Hospital. In December, 1842, he was appointed assistant-surgeon, and on the retirement of Mr. Tuson he was elected one of the senior surgeons to that institution. Mr. De Morgan was a man of great accomplishments and unusual ability. He was elected a Fellow of the Royal Society for a paper on the Structure and Development of Bone in 1853, which he had written in conjunction with his friend Mr. Tomes. He wrote the article "Erysipelas" in Holmes's System of Surgery, and published his views on the Local Origin of Cancer in his book on that subject in 1872. He also related his experience on the origin of cancer in the very able address with which he opened the debate on cancer at the Pathological Society on March 7th, 1874. All that he said on cancer was worthy of strict attention, for the disease had been the study of his life, and his experience of nearly thirty-four years in the cancer wards of the Middlesex Hospital gave him the right to speak with authority. His conclusions were not hurriedly drawn, but were the result of much thought and careful observation. The versatility of his powers is shown in the lectureships which he held in succession at the Middlesex Hospital. In 1841 he was appointed lecturer on Forensic Medicine, and in 1845 he succeeded Mr. Tuson to the chair of Anatomy. He afterwards lectured for many years on Physiology, and, on the retirement of Mr. Shaw, became the sole lecturer on Surgery. In addition to his scientific attainments he was a good musician, and thoroughly understood the science of music. He was also a very clever draughtsman, and possessed a wonderful facility for drawing caricatures.

Mr. De Morgan was a man of great character, with strong religious feelings and dominant convictions. Every act of his life was regulated by his own rigid laws of what was right. It was this high standard of character which secured to him so many friends, but it was also the cause of his making some enemies. His manner was very reticent and sometimes cynical; he was a good observer and accurate in all that he did. Although strict and punctual in the discharge of every duty, he possessed a seeming apathy and an apparent indifference to worldly success. He held before himself the straight and narrow road of right. His voice was strong against fraud and overgreed for fees, but although he denounced the bad he never envied their prosperity.

His loss is greatly felt by all connected with the Middlesex Hospital, for he was a tie between the old and present students, and by his death the link has been severed. He had been associated with the school ever since its formation in 1835, and in his day he had served with Sir Charles Bell, Sir Thomas Watson, Herbert Mayo, Moncrieff Arnott, and others of the old Middlesex staff, and in him were collected all the traditions of the bygone days.

His influence amongst the students was strong for good, and by all he was highly respected. His last act in this world corresponded to the tenour of his life; it was one of kindness to a dying man. On Thursday, April 6th, he was apparently in his usual health, and on that night he sat up with his old friend Lough, the artist, who was seriously ill, and died the following day. He returned home in the cold of the early morning, and about ten o'clock on Friday was seized with the severe rigor which ushered in the illness which terminated in his death on the morning of April 12th. Few men are mourned and missed like Campbell de Morgan. His great kindness and extreme liberality are known only to those who have been benefited by him. He never spoke of his deeds, but there are left to sorrow over his loss those to whom he truly behaved as a father to the fatherless.

He was married to a Miss Hobson about the year 1846. He had the misfortune to lose his wife about seventeen years ago. The loss was deeply felt, and from it he never completely recovered. He has left two sons; the eldest, in the Bengal Engineers, was in India at the time of his death, but the younger was with his father at the last.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—At a meeting of the Council on the 13th inst. the following members were elected Fellows of the College:—

Hough, James, L.S.A., Cambridge.
Leigh, John, L.S.A., Pontypridd.
Pollard, William, L.S.A., Torquay.

The following gentlemen having passed the required examination for the diploma, were duly admitted Members of the College at meetings of the Court of Examiners on the 18th and 19th inst.:—

Atkinson, Richard, Carlisle.
Barrs, Alfred G., M.D., Leicester.
Batterbury, Richard L., M.B., Haverstock-hill.
Best, George Payne, Brompton.
Bowen, Edward, Southsea.
Bradley, Robert, Shepherd's-bush.
Bradshaw, James D., Bowdon, Cheshire.
Bruce, Robert, L.S.A., Old-street.
Bull, James W., Chislehurst.
Burnham, George H., M.B., Peterborough, Canada.

Cane, Howard, Queen-square.
Carter, Howard B., Watling-street.
Charasse, Thomas F., Birmingham.
Clarke, Robert H., Tavistock, Devon.
Davies, Francis J., Newport, Monmouthshire.
Eccles, Arthur S., Plymouth.
Ellis, Joseph W., L.S.A., Willingham, Cambs.
Fisher, Thomas, L.S.A., St. Michael's-on-Wyre.
Foster, Henry, York.
Frankish, William J., Kirmington, Lincoln.
Fraser, Donald B., M.D., Ontario, Canada.
Griffith, David C. B., Surbiton.
Hodson, Robert D., Bath.
Honeywill, Silas, Lee, Kent.
Hunt, Joseph W., Mildmay-park.
Hyne, Frederick A., L.S.A., South-square, Gray's-inn.
Judson, Thomas R., Forest-hill.
Kay-Shuttleworth, Lionel E., Cromwell-road.
Mackay, James J., Fermoy, co. Cork.
Merriman, John W. C., Kensington-square.
Murphy, Henry Howard, L.R.C.P., Brompton.
Parker, Arthur F., Clifton, Bristol.
Pearse, Joshua S., L.R.C.P., Plymouth.
Pinnell, Thomas M., St. John's-wood-terrace.
Scott, John H., M.B., Edinburgh.
Sloman, Herbert, L.R.C.P., Farnham, Surrey.
Southam, Frederick A., Manchester.
Taylor, James, L.S.A., Bristol.
Thompson, Arthur H., Gomersal, Yorkshire.
Tirard, Nestor J. C., Curzon-street.
Tuke, George M., Sittingbourne, Kent.
Verrall, Thomas J., Brighton.
Walker, George, Wimbledon.
Warren, Charles E. H., Edinburgh.
Wilkins, Robert S., Newport, Isle of Wight.
Wilson, Arthur Huelin, L.R.C.P., St. George's Hospital.

Of the 59 candidates examined on the above-mentioned days, 13 failed to satisfy the Court of Examiners, and were referred for six months' further professional study.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine and received certificates to practise on April 13th:—

Clarke, Reginald, Craven-hill, Hyde-park.
Colquhoun, Daniel, Upper Kennington-lane.
Diggle, Charles Frederick, Todmorden, Lancashire.
Foster, William, Westminster Hospital.
Gascoigne, William Ellis, Spanden House, Derby.
Hancock, Charles James, Bath.
Harrison, Edwin, Wrexham.
Head, Percy Turner James, East Grinstead.
Webster, John, Market Deeping.

The following gentlemen passed the Primary Professional Examination on the same day:—

Thomas Frederick Isaacson Blaker, Guy's Hospital; Thomas Lloyd Brown, William Andrew Shoulbred, St. Bartholomew's Hospital; George Arthur Cardew, Queen's College, Birmingham; George Harcourt Hornsby, Richard Arthur Newton, General Hospital, Birmingham.

DR. LATHAM, the Downing Professor of Medicine, has given notice that he will resume his course of lectures on Materia Medica and General Therapeutics on Tuesday, April 25th. The lectures will be delivered during the ensuing Easter Term in the New Lecture-room, Downing College, Cambridge, on Tuesdays, Thursdays, and Saturdays, at 9 A.M.

QUEEN'S UNIVERSITY IN IRELAND.—The following have been appointed Examiners for one year:—In Medicine, H. Charlton Bastian, M.D., F.R.S.; in Surgery, William Stokes, M.D.; in Midwifery, &c., J. Guinness Beatty, M.D.; in Materia Medica, Professor Pye, M.D.; in Medical Jurisprudence, William Stoker, M.B.

Medical Appointments.

BARNES, G., L.R.C.P.Ed., M.R.C.S.E., L.S.A.L., has been reappointed Medical Officer of Health for the Chard Rural Sanitary District, at £300 for one year.

BARTON, J. K., L.R.C.P.L., M.R.C.S.E., has been appointed Ophthalmic House-Surgeon to St. Bartholomew's Hospital, vice Sheeby, whose appointment has expired.

BRADLEY, S. M., F.R.C.S.E., has been appointed a Surgeon to the Royal Infirmary, Manchester.

BROWNE, D. J., L.K.Q.C.P.I. & L.M., L.R.C.S.I., has been appointed Medical Officer to the Workhouse and Fever Hospital of the Londonderry Union, vice Cuthbert, deceased.

CHAMBERS, T. S., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Medical Officer and Public Vaccinator for the Raynham District of the Walsingham Union, Norfolk, vice Coomber, resigned.

COLLYNS, R. T. P., has been appointed Resident Medical Officer to Atkinson Morley's Hospital, Wimbledon, vice Baber.

CURRIE, A. S., M.B., M.R.C.S.E., has been appointed Resident Medical Officer to the Birmingham and Midland Free Hospital for Sick Children, vice Johnston, resigned.

EMMERSON, W. L., M.D., L.R.C.S.Ed., L.S.A.L., has been appointed Public Analyst for the Counties of Leicester and Rutland for one year, vice Young, whose appointment has expired. 10s. 6d. per analysis; minimum £70 for the year.

FLINN, D. E., L.K.Q.C.P.I., L.R.C.S.I., has been appointed a Medical Officer to the Brownhills, Conduit, and Highbridge-row Colliery Companies, near Walsall, vice Cooke, deceased.

HAWES, G. H., M.R.C.S.E., has been appointed a House-Physician to St. Bartholomew's Hospital, vice Hastings.

HARDIE, J., M.D., L.R.C.S.Ed., has been appointed an Assistant-Surgeon to the Royal Infirmary, Manchester, vice Bradley, appointed a Surgeon.

HARDING, C. F., M.D., has been appointed Medical Examiner of Army Recruits for the District of Whittlesea.

HARTFORD, Dr. H. W., has been appointed Medical Officer and Public Vaccinator for the Eastern District of the Christchurch Union, vice Sterling, resigned.

HEMSLEY, W. B., A.L.S., has been appointed Lecturer on Botany at St. Mary's Hospital Medical School, vice Trimen, resigned.

LAKIN, C., L.R.C.P., L.M., L.S.A., L.A.H., has been appointed one of the Medical Officers to the Archdeacon Lane Friendly Society, vice Fullagar, deceased.

MACKELLAR, A. O., M.D., M.R.C.S.E., L.S.A.L., has been appointed an Assistant-Surgeon to St. Thomas's Hospital, vice Arnott, resigned.

MASTERMAN, G. F., M.R.C.S.E., L.S.A.L., has been appointed Medical Officer and Public Vaccinator for the Sapiston District of the Thetford Union, Suffolk, vice Taylor, resigned.

MAXWELL, P., M.D., F.R.C.S.Ed., has been appointed Medical Officer and Public Vaccinator for the Boston District and the Workhouse of the Boston Union, vice Butler, resigned.

NEWCOMB, F., M.D., M.R.C.S.E., L.S.A.L., has been appointed Medical Officer and Public Vaccinator for the Ropsley District of the Grantham Union, vice Growcock, resigned.

PASLEY, N. C. B., L.R.C.P.L., L.R.C.S.I., has been appointed District Physician, Port of Spain, Trinidad.

PLOWMAN, Mr. S., has been appointed Apothecary to St. Thomas's Hospital, vice Jones, resigned.

STOCKWELL, G. T., M.R.C.S.E., has been appointed Medical Officer for the Dunster District of the Williton Union, vice Norman, resigned.

SUTTON, H. G., M.R.C.S.E. & L.M., L.S.A.L., has been reappointed Medical Officer of Health for the Sittingbourne Urban Sanitary District for six months.

WALSHAM, W. J., M.B., C.M., F.R.C.S.E., has been appointed a Surgeon to the Metropolitan Free Hospital, vice Sheffield, deceased.

WHARRY, R., M.B., M.R.C.S.E., has been appointed a House-Physician to St. Bartholomew's Hospital, vice Harris.

Births, Marriages, and Deaths.

BIRTHS.

BENNETT.—On the 16th inst., at Upper Berkeley-street, the wife of Dr. H. Selfe Bennett, of a daughter.

FITZGERALD.—On the 9th inst., at Upper Merrion-street, Dublin, the wife of C. R. Fitzgerald, M.D., of a son.

GRAY.—On the 9th inst., at Beaumont-street, Oxford, the wife of Edward B. Gray, M.D., of a daughter.

JAGO.—On the 15th inst., at Arundel-square, Barnsbury, the wife of T. Jago, M.R.C.S.E., of a daughter.

KILNER.—On the 5th inst., at Ladbroke-grove-road, the wife of Walter John Kilner, M.B., of a daughter.

PHIBBS.—On the 8th inst., at Boundary-road, St. John's-wood, the wife of Robert Featherstone Phibbs, L.R.C.P.Ed., of a son.

WILSON.—On the 8th inst., at Foregate-street, Worcester, the wife of James Wilson, M.D., of a son.

WOODGATES.—On the 12th inst., at Southernhay, Exter, the wife of Samuel Henry Woodgates, M.D., of a son.

MARRIAGES.

DENTON—PARADISE.—On the 18th inst., at St. Mary's Parish Church, Stamford, by the Rev. John Denton, M.A., Vicar of Ashby-de-la-Zouch, cousin of the bridegroom, assisted by the Rev. H. C. Abdy, M.A., Vicar of St. Mary's, Stamford, Thomas J. Denton, M.D., of Steeple Claydon, Bucks, to Florence Elvena, daughter of John Paradise, Esq., J.P., of Stamford. *No cards.*

TAYLOR—RANDALL.—On the 11th inst., at St. Mary's, Stoke Newington, Arthur Norton Taylor, M.R.C.S.E., to Emily Lloyd, daughter of Alfred Mayor Randall, M.R.C.S.E.

DEATHS.

BATEMAN.—On the 17th inst., at East Bridgeford, Notts, deeply and deservedly lamented, Charles Bateman, Esq., M.R.C.S.E., &c., aged 45. Friends will please accept this intimation.

GARTY.—On the 18th inst., at Clyde-terrace, Stockwell-road, Francis Boyle Garty, M.R.C.S.E., aged 59.

IRELAND.—On Easter-day, at Weymouth, John James Ireland, M.R.C.S.E., aged 72.

MACKAY.—On the 12th inst., Allan Douglas MacKay, M.B., of Stoney Stratford, aged 45.

MILLER.—On the 3rd inst., at Ventnor, Surgeon-Major John Massey Miller, retired, Madras Army.

RYMER.—On the 11th inst., at St. Lawrence, near Ramsgate, James Rymer, M.R.C.S.E., aged 86.

TAYLOR.—On the 8th inst., at Whitworth, James Eastwood Taylor, M.R.C.S.E., aged 62.

TROUNSDALE.—On the 31st ult., at Harrogate, Thos. Trounsdale, L.R.C.P.Ed., aged 53.

WILTON.—On the 11th inst., at Bishopwearmouth, Sunderland, John Wilton, M.D., aged 80.

WINTER.—On the 9th inst., at Westbury, William Thomas Winter M.R.C.S.E., aged 37.

[N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*]

Notes, Short Comments, and Answers to Correspondents.

A FEMALE ARMY SURGEON.

In the interesting recollections of the Earl of Albemarle, published under the title of "Fifty Years of my Life," reference is made to one of the most singular circumstances that probably ever occurred in the annals of any public department. We allude to the remarkable career of an army surgeon, who, after having passed through every grade of the service, from the lowest rank to that of Inspector-General, died in the year 1865 in lodgings in London, when the discovery was made by the nurse in attendance of a fact which had long been suspected—that the deceased was of the feminine gender. This occurrence, which we have every reason to believe to be authentic, naturally attracted a great deal of attention at the time; but the story is so strange that it will well bear telling over again. Lord Albemarle, during the time that Lord Charles Somerset was Governor of the Cape, met a Dr. James Barry, who was staff surgeon to the garrison, and the Governor's medical adviser. "Lord Charles described him to me as the most skilful of physicians and the most wayward of men. He had lately been in professional attendance upon the Governor, who was somewhat fanciful about his health; but the Æsculapius, taking umbrage at something said or done, had left his patient to prescribe for himself. I had heard so much of this capricious yet privileged gentleman, that I had a great curiosity to see him. I shortly afterwards sat next him at dinner at one of the regimental messes. In this learned Pundit I beheld a beardless lad, apparently of my own age, with an unmistakably Scotch type of countenance—reddish hair, high cheek bones. There was a certain effeminacy in his manner, which he seemed to be always striving to overcome. His style of conversation was greatly superior to that usually heard at a mess-table in those days of non-competitive examination. A mystery attached to Barry's whole professional career, which extended over more than half a century. While at the Cape he fought a duel, and was considered to be of a most quarrelsome disposition." This Dr. James Barry was at the head of the list of Inspectors-General in 1865, when he retired from the service, and died, as we have said, in London in that year. Lord Albemarle refers to its having been officially reported that this said officer was a woman, and adds that the late Mrs. Ward, daughter of Colonel Tidy, stated to him her belief that the doctor was the legitimate granddaughter of a Scotch Earl, and that the *soi-disant* James Barry adopted the medical profession from attachment to an army surgeon who had not been many years dead. Be all this as it may, there can be no doubt that the officer in question possessed physically the characteristics of that sex from which officers are not usually drawn. The appearance, development, voice, and so on were indicative of the female sex, and, in many striking respects, the mental and moral qualities pointed in the same direction. As years crept on, this officer, instead of developing into an old woman, which some sarcastic and badly-disposed people might be tempted to declare an everyday occurrence, exhibited the tastes, temper, and qualities of an old maid. That the woman—a married one, by the way—who laid out the body was firmly convinced of its being a female is undoubted. Some allowance may be made for a natural tendency to exaggeration; but it is, nevertheless, the fact that, notwithstanding a certain impulsiveness and querulous disposition, Dr. James Barry had the courage of her opinions and a will of her own. Although the secret of her sex was often suspected, she managed, with indomitable will and a steadiness of purpose that was never shaken, as well as a circumspection always alert, to play the part and discharge all the duties of a medical officer. What an autobiography such a life would have made!

Contab.—Our correspondent will find the subject noticed in another column.

WATER FROM SURFACE WELLS.

DR WHITMORE, medical officer of health for Marylebone, writes as follows in his last Monthly Report:—

"The dangerous condition of the water taken from the pump at the corner of Great Portland-street and Chapel-street furnishes additional evidence of the fact that all the superficial springs in the parish are more or less polluted with sewage, and it is certain that there are no means of purifying them. With but one or two exceptions, all the pumps in the parish, under the control of the vestry, have been removed long ago, and it is to be hoped that those which remain will speedily follow; but there are still no inconsiderable number of private pumps situated in stables and other parts of owners' premises, which draw their water from similar sources, such water in a great many cases being used for drinking and domestic purposes."

BARKING TOWN.

WE hear that Mr. H. H. Mason has been appointed temporary medical officer of health for Barking Town, in place of Mr. F. H. Parsons, who has retired through ill-health. The sanitary measures necessary to improve the health of the town have been frequently pointed out, without effect, by the late medical officer in his reports. So long as a great part of the town remains practically undrained, and the sewage of the other portion is emptied into the Creek, no permanent improvement in the health of Barking can fairly be expected.

Mr. Sexton's letter on "Subcutaneous Injection of Quinine, &c.," shall appear next week.

Dr. Phillips.—We do not usually notice paragraphs like the one forwarded.

WESTON AT BIRMINGHAM.

IT will surprise no medical man to learn that the success of Mr. Weston's walk at Birmingham was marred by the occurrence of vertigo. It is not an unprecedented sensation in Mr. Weston's experience. He had occasionally slight degrees of it in his London walks, and in some of his American ones it was considerable. What wonder that after walking 91 miles without stopping on the previous day, and waking out of a sleep 3½ hours long, as might be supposed to follow this feat, he should feel giddy. The giddiness must have been very decided to compel Mr. Weston to rest twice, once for about an hour, and again for 6 hours and 20 minutes. At ten in the morning, after this second rest, Mr. Weston set off "at a brisk pace and with determination," and at the end of 38 hours he had walked 129 miles, instead of 150 as he proposed. His 110th mile was made in 10 minutes 45 seconds, the quickest made by him in England. A striking fact, though a slight one, is reported of Mr. Weston's competitor, Smalley. He retired from the contest at 7 minutes to 6, after completing 94 miles all but one lap. The inability to do one lap more is very suggestive of great exhaustion. The feat is, of course, creditable to Smalley; but this exhaustion and Mr. Weston's vertigo convince us more deeply than ever that such exhibitions of endurance are made at great risk, and are difficult of justification. Walking is a natural thing; but walking 150 miles in 38 hours is not according to nature.

Colonial Surgeon should inquire of the Clerk of the General Medical Council.

There must be some guarantee of identity.

Mr. D. E. Moore should consult his medical attendant.

USELESS INQUESTS.

To the Editor of THE LANCET.

SIR,—As there seems at the present time to be a discussion in your columns *apropos* of death certificates generally, and of coroners' and unqualified persons' certificates in particular, it would be interesting to know whether the certificates of coroners (not having any medical skill to guide them) are not equally valueless with those of unqualified persons generally. I opine that if either have any value, those of the unqualified practitioner are to be esteemed the most; for we certainly cannot have more stupid, useless, or false certificates than "Death from natural causes," "Death by the visitation of *God*" (the latter word must be a misprint for *sin*). I have been registered now about two years, and the following cases have come under my observation. There are a number of others, but these are all I can call to mind for the moment.

1. Child, aged eleven months. Well one hour; dead the next. Inquest held. No medical evidence.

2. Man, aged about forty-five. Dead on arrival. No inquest.

3. Woman dead in bed. Wall bespattered with probably thirty ounces of blood. This case I heard nothing further of.

4. Woman dying when I arrived, in a state of profound coma. In this case I gave the certificate thus: "Coma. *Seen by me once.*" This had no effect. What the coma depended upon I know no more than the man in the moon.

5. Woman dead in bed on arrival. No medical evidence called. I am not aware whether an inquest was held in this case or not. Twelve months afterwards it transpired that she was robbed at or about the time of her demise of over £100 worth of jewellery.

6. Child dead. Went to bed well; dead in bed next morning. I was not called.

7. Man dead in bed at a lodging-house, with fractured leg, said to be of old-standing. I was not called.

8. Man dead in lodging-house, after severe purging and vomiting, having partaken freely of spirits. No medical evidence.

9. Man dead in a privy in a very low neighbourhood. No medical evidence.

10. Man died from blood-poisoning from injury. I gave a full and proper certificate; but in this case, to reverse the order of affairs, an inquest was held, and I was called to give evidence. The coroner told the jury they were not called to ascertain the cause of death, but to find out how the injury was brought about.

11. Boy run over in the street; picked up dead; brought into the surgery, and laid for some hours upon the surgery counter; nobody knowing who the boy was.

In Case 1, the child was aged eleven months. It had four teeth in the upper jaw and four in the lower; it had never had any illness, and was apparently quite well a few minutes before its death. An inquest was held, no medical evidence being called, and the verdict was "Died from natural causes." Now, is death at eleven months old a natural sequence? or is it not rather very unnatural?

When a student at hospital I well remember my lecturer on Forensic Medicine telling me, when called in to a case of sudden death where there was the slightest ground for suspicion, to note everything of importance, and put it down at the time, such as the state of the body, nature of the vomit, the time of day, &c. &c., all of which things, Mr. Editor, you know so much better than I can tell, and all of which I used rigidly to attend to. But since then I have learned a great deal better how to economise time, and I don't mind confiding to you what it is, but pray don't let the public know. "I never note anything at all." What must be the natural result of such a lax mode of doing business? There is but one answer. The day may come when I shall be called in to a case of mysterious death; the patient will have been *poisoned, hanged*, or what not. The coroner will summons me for my advice and assistance, and I shall tell him—*What?* The echo says "What?" "Well, I shall say, "Mr. Coroner, as you never called me before, and as you always appeared to know so much about all my other cases, I thought you would know all about this one as well, and therefore I have simply noted nothing. I did not look to see whether his throat was cut! I could not say whether he had a rope round his neck! I have not even soiled a clean handkerchief with the vomited matter! I have not noted the time! I have not saved any of the empty phials!" And, as a result, another murderer escapes the hangman!

Yours faithfully,

April, 1876. ONE OF A NUMBER WHO DOES NOT NOTE ANYTHING.

THE SHEFFIELD FEVER EPIDEMIC AND THE SHEFFIELD RIVERS.

A MEMBER of the Sheffield Town Council (Mr. F. Brittain), at a recent meeting, rendered good service to the borough by calling attention to, and raising a discussion upon, the condition of the river Porter and its relation to the now declining fever epidemic, which for many months has fatally prevailed. This fever epidemic followed the floods in October last, and was especially fatal in the streets along the banks of the river. The rising of the water drove the sewage back into the houses, the cellars and basements of which were literally flooded with the filth, rendering the houses uninhabitable. In one of the houses in Pomona-street, which was thus flooded with sewage, no less than four fever deaths occurred. It appears that since the sewers were laid, the bed of the river has risen above the level of their outfall; indeed it was stated that the river is now five feet higher than it was but a few years since, and that thousands of tons of "wheelswarf" have been thrown into the stream. It was suggested by a member of the Council that the manufacturers living on the stream, who have caused all this mischief, misery, and death, ought to be made to purify the river. That the river should have been allowed to be used as a shoot for refuse, and the outfall of the sewers thus to be choked and buried, shows an almost incredible amount of apathy on the part of the sanitary authority. It is, moreover, the less excusable, because the condition of the Sheffield rivers was pressed upon the attention of the Town Council by Dr. Griffith, their medical officer, in his first Annual Report published two years ago. The necessity for hospital accommodation for non-pauper cases of infectious diseases, which was so severely felt during the fever epidemic, has in a similar way been ignored by the Sheffield sanitary authority, although continually pressed upon their notice. At a meeting of the Town Council above referred to, the Health Committee were instructed to report to the Council as to the best measures to be adopted to remedy the evil arising from the condition of the river. It remains to be seen whether any active measures will be taken to stop the serious pollution of the Sheffield rivers by solid and liquid household or trade refuse, which has rendered them so dangerous to the health of the borough.

A Blockhead's communication shall appear next week.

SPHYGMOGRAPHIC TRACINGS.

To the Editor of THE LANCET.

SIR,—In the letter addressed to you, and which appeared in THE LANCET of April 1st, Dr. Handfield Jones asks the question, "whether I am of opinion that all flat-topped tracings are abortive, and do not truly write the character of the pulse?"

As the sphygmograph is still in its infancy, one ought not to be too dogmatical, but I must admit I have always looked upon flat-topped tracings as a mechanical defect, caused by the needle being for a certain time at rest while the slide was travelling on, and not due to any physiological or pathological condition of the circulatory system. I have always thought that, granted the pressure of the spring upon the artery was of proper force, and the needle moved lightly over the smoked glass or paper, the tracing should be peaked when the arterial tension was strong (the greater the tension the higher and sharper the peak), and rounded when the tension was slight; and I have set aside flat-topped tracings as untrue. Of course I am open to conviction, and it is quite possible I have been working under error.

If in my former letter I gave any offence to Dr. Handfield Jones, as he seems rather to infer that I accused him of want of knowledge in the use of the instrument, it was done unintentionally. I read his two lectures with great benefit, and sincerely hope he will continue to give us the fruits of his labours. I feel sure Dr. Handfield Jones will admit that we have not yet arrived at anything like proficiency in the application of the sphygmograph. It seems still a moot point with some as to what are the characteristic tracings of health; therefore, how much more doubt must exist over those of disease. Being still sceptical as to the cause of the flat-topped tracing, I should like to know the opinions of other workers; and as the subject is one of importance to the profession, I think, Mr. Editor, with your permission, it might be advantageously discussed in your valuable paper. That the sphygmograph will in time prove a useful aid to diagnosis in many diseases, any one who has given attention to the instrument will, I am certain, bear testimony; and it is very important the profession should settle what are the characteristic writings in health and disease.

I agree with Dr. Handfield Jones that cutting short the up-stroke does not essentially alter the significance of the tracing, and those experienced in the use of the instrument can easily make allowance for any such defects. But when we take into consideration that there must be at all times learners, for their sakes it is advisable to avoid any mechanical imperfections. For instance, it would be difficult for a novice to understand that tracing Fig. 2, *b* and *d*, as given in Dr. Handfield Jones's letter, were taken from the same pulse.

I am, Sir, yours faithfully,

Cheltenham, April 10th, 1876. ALEXANDER INGLIS.

EFFECTS OF INTERMARRIAGES.

THERE is (says a correspondent in *The Times*) a little town in the Province of Santander, Spain, Potés by name, which, until eighteen or nineteen years ago, was quite shut off from all the rest of the world. Its inhabitants, from their ever-recurring intermarriages, had become quite a race of dwarfs. On market days might be seen the priests (their concubines riding *en pilion*), with long black coats and high black hats, riding in to purchase the simple provision for the week's consumption—men of little intelligence and no learning, sprung from the lowest ranks. About eighteen years ago the Galician labourers, or Gallegos, from the mines of Galicia, swarmed into the town for lodging &c., and since their colonisation the population has increased in strength, stature, education, intellect, and morality. Their intellects, also, have improved—intellects which had been stunted, dwarfed, and ruined by their frequent intermarriages.

Mr. A. Watkins should consult his medical attendant.

DR. BONWILL'S METHOD OF INDUCING ANÆSTHESIA.

IN an introductory lecture by Dr. A. Hewson at Pennsylvania Hospital, reported in the *Philadelphia Medical Times*, there is a description of a method of diminishing or allaying sensibility by rapid inspirations, known as Dr. Bonwill's method, which is alleged to be efficacious and applicable to cases where some measures are required to diminish emotional dread, or induce such an amount of insensibility as will admit of the patients being manipulated or examined with the requisite degree of care. As the effect of rapid and deep respirations after violent running or of blowing hard to ignite a fire, a certain amount of confusion of sight and bewilderment of mind is sometimes experienced. With these effects Dr. Bonwill recognised that some numbness of the sentient nerves was associated, and, pursuing the subject further, he was enabled to bring it to practical use in his profession—that of dentistry. It was from a demonstration of the power of this method of procedure to induce sufficient anæsthesia to allow of the painless extraction of a tooth that Dr. Hewson was led to study the subject. He states that he has used it with gratifying results in stitching wounds, in handling over-sensitive parts, and in probings and the like. In a case where a boy had sustained a severe sprain of the left wrist from a fall upon the ice, the patient was directed to respire rapidly, which he did for two and a half minutes, when the injured wrist was freely manipulated without pain. In some other cases, owing to the nervousness of the patients, they could not be got to continue the rapid respirations, and the experiments failed; but Dr. Bradford, the resident surgeon of the Pennsylvania Hospital, was induced to try the process himself in the presence of the class. It was his first attempt, and it was made while in the sitting position. Breathing rapidly for about three minutes was, first of all, attended with a tingling sensation, especially of the tips of the fingers, and a feeling as though the surface was swelling. Then there followed a dizziness or confusion in the head, without loss of consciousness, but with an inability to resist or act independently. He had no recollection of being hurt by a pin, which he found had been stuck into his flesh whilst anæsthetic from this rapid breathing.

Mr. E. Beales is thanked.

HUMAN RUMINANTS AND MALINGERERS.

To the Editor of THE LANCET.

SIR,—The case detailed in your last number by Dr. Mackintosh, of Southsea, is a very interesting one, but is by no means so uncommon as the writer supposes, nor is there anything at all "incredible" in the power which the patient possesses of vomiting at will. Magendie, Todd and Bowman, and other writers on Physiology state that it is a power possessed by many individuals, and describe the process with considerable minuteness. Naval and military surgeons with a good scent for malingerers are practically well acquainted with the fact that the power of voluntary vomiting is by no means an uncommon one, although probably sufficient attention has not been hitherto paid to its clinical signification in our naval and military hospitals. The often-repeated tale of some well-nourished patient, "Vomited my breakfast again this morning, sir," requires a watchful investigation, not always unrewarded by the detection of fraud, and hence we find that writers on feigned diseases have devoted a considerable share of attention to this subject.

Paris and Ponblanque mention a case where a young woman in a convent swallowed a quantity of bullock's blood previous to being visited by a physician, and vomited it up in his presence; and Orfila relates a very disgusting case which occurred in La Charité of a girl who swallowed her own faces in order to eject them again at the visit hour. Beck, in his Medical Jurisprudence, gives a case of periodical vomiting which occurred night and morning at the physician's visits. In the interval the patient ate his usual allowance of food without injurious effects, and on his being constantly watched the vomiting was found to cease. In the twenty-sixth volume of the *Edinburgh Medical and Surgical Journal*, Staff-Surgeon Marshall reports the case of a soldier, who, on being ordered to embark for India, was suddenly seized with a propensity to eject his food. From the first there was no doubt that the affection was voluntarily excited; and after the patient was told of the unusual nature of his malady, a grave consultation was held, the conclusion of which was that, should the vomiting not abate, his belly was to be opened for the purpose of ascertaining the cause of the regurgitation of food. The urgency of the symptoms, of which he had formerly complained so much, rapidly subsided, and in forty-eight hours he was on his way to India without a symptom of uneasiness. The same military surgeon, to whom we are indebted for much valuable information on simulated diseases, states that at one time in the General Hospital in Dublin no fewer than five men in one ward regurgitated their food, so that the disability was partially epidemic, but none of the men were invalided.

Vomiting, indeed, is not always to be considered as an objective symptom of disease, and that it is a power easily acquired every Eastern juggler knows, and turns to good professional account. When the food is thrown up in an *undigested* state, and the vomiting confined to the period of the morning or evening visits, whilst the patient remains well nourished, malingering may be strongly suspected, especially when any motive for fraud exists. During the five years ending 1873 nearly one hundred cases returned as "dyspepsia" were invalided from Her Majesty's fleet, and the subsequent history of many of them would no doubt present us with an amusing but pitiful history of fraud, and entail upon some of us the unpleasant sensation of having been "done."

Although not of opinion that malingering is now carried on in the public services to any great extent, the existence of such a power as is exemplified in Dr. Mackintosh's case has, I think, been too much overlooked. Had his young carpenter been less ambitious, and chosen to have entered Her Majesty's service as a soldier or sailor, he might, with judicious management, have spent many peaceful days in Netley or Haslar, seen Greater Britain at his country's expense (including a trip to the "hills" in the hot season), and instead of having to "pave his rugged way to the heights of everlasting fame" (whatever that may mean), it is not improbable that he might have settled down quietly as one of Her Majesty's pensioners!

Yours faithfully,

Plymouth, April, 1876. ROBERT NELSON, R.N.

THE SPREAD OF FEVER.

A COMMUNICATION in *The Times* calls public attention to the great value of private wards in the London Fever Hospital. A provision of this kind appears to us of real importance and value. In the majority of cases of infectious fevers among the upper and middle classes there can be no complete isolation, and consequently no safeguard against their extension to other persons in the same household. Where a disease like scarlatina, for instance, is concerned, the difficulties that have to be contended against in this respect are commonly great and sometimes insuperable. The immense practical value of an institution like the London Fever Hospital, which provides accommodation to meet the requirements of patients belonging to different classes of society, must, we think, be obvious to everyone. It cannot be too generally known that, in addition to the wards for what may be termed hospital patients, there are private rooms at this hospital both for males and females in every way suitable for the accommodation of cases of infectious fevers, and everything is provided in the shape of medical attendance and nursing. Besides these private rooms, domestic servants, *employés*, and others are received into the wards of the institution at a very small cost. We consider that we are rendering a public service in calling attention to these facts, and we notice with much regret that fears are entertained lest the usefulness of this hospital be eventually seriously impaired for lack of funds. It is almost entirely supported by voluntary contributions, and, as everyone is interested in preventing the spread of infectious diseases, there would appear to be every reason, on selfish grounds, if on no other, why such an institution should be maintained in a large city like London.

THE MEDICAL SERVICE OF INDIA AND HONORARY REWARDS.

To the Editor of THE LANCET.

SIR,—It is to be desired and hoped that in future distributions of the honour of the Star of India, an Order specially instituted for the reward of services in India, the medical service may be permitted to participate more freely than it has hitherto done; for, singularly enough, though this service has pioneered the way to the affections of the people of the wildest regions, who, while they cannot comprehend the British methods of land settlement and taxation, at once appreciate the surgery and medicine of the West, and come hundreds of miles to have their stones and cataracts extracted, or their tumours and goitres removed; though it has effected so much substantial good throughout the length and breadth of the land, from the days when its early representatives cured Emperors and Princes of their diseases, and so gained for the East India Company grants of territory and other privileges, down to later times, when its members have fought against frequent cholera epidemics, or have suffered with their military companions the dangers of many a battle and siege, and have given their lives freely in the execution of their duty, its members have been strangely overlooked as regards honorary rewards, and have hardly had the barest justice done them. On a comparison of the distribution of honours to several services, it seems that the officers of the active military service of the Bengal army have received the Orders of the Bath, Star of India, and Victoria Cross in the proportion of nearly 8 per cent.; those of the covenanted civil service of Bengal in about 3·50 per cent.; those of the British medical service in rather more than 3 per cent.; those of the Bengal medical service in rather more than 1 per cent. One assistant-apothecary in Bengal has received the Victoria Cross; but no surgeon of the Indian army has been deemed worthy of it, though one at least can be mentioned who was more than once strongly recommended for it.

It is a matter of sincere congratulation that Sir J. Fayrer has received the Knighthood of the Star of India; but he can surely not be the *only* member of the Indian medical service who deserves to be so decorated. His name is indeed imperishably connected with the heroic defence of the Lucknow Residency, and he has been greatly and most justly honoured; but there are other surgeons whose services were acknowledged together with his in the despatches of that memorable time, and whose "untiring industry, extreme devotion, and great skill in the discharge of onerous and most important duties" (*vide* General Inglis's despatch), have never received any sufficient recognition. In campaigns like those of Abyssinia or Ashantee, honours are heaped on fortunate officers, two and three frequently on one individual, for carrying a despatch or for riding over a deserted battle-field; yet here are men who for months performed their difficult duties, under the most trying circumstances, in a manner to gain the approbation of their General, and the acknowledgments and praises of the Governor-General and Secretary of State in his place in Parliament, whose breasts are undecorated, and whose names are forgotten.

It is true that medical officers work from a sense of duty, and do not look for rewards other than those which come to them from a consciousness of its performance; still they are like other men, and when they see freely bestowed on those around them, who have but shared their dangers and trials, honours from which they themselves are excluded, they cannot but feel distressed and mortified. The late Sir Ranald Martin, a distinguished member of the Indian medical service, in advocating the claims of army medical officers to honorary distinctions, truly said years ago in your columns: "The reward of individual services is an important part of the debt due by the State to its officers, but its importance does not end here. For one individual marked out for reward and distinctions, we make a hundred others emulous of similar rewards, and eager, through the exercise of their talents and the amount of their services, to deserve similar recompenses" (*vide* THE LANCET, Sept. 22nd, 1849).

Would it be asking too much to beg you to urge on Government with your powerful pen the claims of Indian army surgeons to a fairer share of honours than they have yet received, and especially to point out that they should not be forgotten in future distributions of the Star of India?

Your faithful servant,

April, 1876. F.R.C.S.

CONVERSION OF AN OLD INTO A PROVIDENT DISPENSARY.

A SATISFACTORY experiment of this kind is reported in the case of the Shrewsbury Dispensary. In six months 2800 have entered as benefit members, and the average weekly attendance is 341. We should be much pleased to hear more frequently of such success.

NASAL CATARRHS TREATED LOCALLY.

To the Editor of THE LANCET.

SIR,—So many persons suffer from nasal catarrh, and some so severely and so frequently, that Dr. Ferrier's communication on the subject will be read with great interest; and as his plan of treatment is readily available and easy of application, it will probably be put to the test in numerous instances. In confirmation of the principle of his method, I may perhaps call attention to the use of tobacco-snuff as a means of curing a cold in the head. I have frequently tested it, and have found it answer extremely well. The first pinch commonly excites sneezing (i. e., in those who are not habitual snuff-takers); but after the second or third pinch the powder remains in the nostrils, and forms a coating of the mucous membrane. A flow of thin serum then begins, and the sense of fulness and obstruction at once subsides. In a few hours the cold is cured, or at the latest survives only for a single night. The snuff should be used freely, and the coating formed by it on the mucous membrane should be left undisturbed for several hours, blowing the nose being meanwhile avoided until all feeling of "stuffiness" in the nostrils has subsided. This remedy, however, is extremely distasteful to some persons, and ladies can rarely be persuaded to try it. To such patients the inhalation of the mixed vapours of ammonia and carbolic acid, in the form known as "Hagner's Olfactory," will be more acceptable, and according to my experience answers almost as well. The formula for this preparation is as follows:—Crystallised carbolic acid, five grains; rectified spirits of wine, twenty minims; liquor ammoniæ, five minims; distilled water, ten minims. A few drops of this solution are placed inside a cone of blotting-paper, and the open end of the cone applied to the nostrils for inhalation, the heat of the hand being sufficient to accelerate the vaporisation of the fluid if necessary. This answers admirably in many cases of simple catarrh of the nasal passages; but if used for catarrh affecting the air-passages, is too irritant, and must be avoided in all such cases. Whether we use snuff or the "olfactory," the good effect seems to be due to the stimulant and constringing effect of the powder or vapour upon the swollen and congested mucous membrane; and Dr. Ferrier's powder no doubt acts in much the same way, having, however, the advantage of being non-irritant, and therefore not being likely to cause sneezing. Perhaps, too, the coating formed by the powders may act as mechanical compressing agencies on the dilated bloodvessels, and may thus prevent a recurrence of congestion after the immediate effects of the first application have gone off.

I am, Sir, your obedient servant,

W. SPENCER WATSON.

Henrietta-street, Cavendish-square, April 11th, 1876.

DEGREES IN MEDICINE AT CAMBRIDGE.

To the Editor of THE LANCET.

SIR,—Your correspondent, "A Professional Working Bee," in his letter published in your last issue, seems to ignore the fact that his ideas, if carried out, would cut at the root of the whole system of University education. A graduate in Arts of one of the older Universities holds a certain position in society, not simply because he is a graduate in Arts, but because he has undergone a certain social training.

Tom Brown's father, to the best of my recollection, did not send his son to Rugby to learn so much Greek and Latin, but he sent him "to learn how to be a gentleman"; and the same holds good for the Universities. A man does not go up to Oxford or Cambridge merely to put the letters M.A. after his name, but rather to serve his apprenticeship as an undergraduate, and by so doing to receive a "hall-mark" (I quote your correspondent's expression) which will stand him in good stead throughout the whole of his after-life. And what I have said of an Arts degree will, I venture to think, equally hold good for a medical one. I think it is perfectly right that any member of the University who has taken up the study of medicine subsequently to his graduating in Arts should be allowed to proceed to the medical degree without being obliged to keep medical terms at that University; but why anybody "who is by Legislature registered, and consequently placed upon an equal footing with University graduates" (?) should be allowed to obtain a degree in Medicine, I utterly fail to see.

By all means let Oxford and Cambridge form an examining body, which would (without the conferring of a degree) testify to a certain standard of knowledge in any candidate who cares to present himself; but "A Professional Working Bee" must be guilty either of gross unfairness, or of ignorance of the cost of a University education, if he wishes that a man who has undergone a few hours of examination only should be placed on a level with another who has spent some years of his life, and perhaps no small portion of his income, in the attainment of his degree.

Yours obediently,

April, 1876. CANTABRIENSIS.

ENGLISH CERTIFICATES NOT VALID IN SCOTTISH ASYLUMS.

To the Editor of THE LANCET.

SIR,—The apparent anomaly to which Dr. Lockie draws attention in this week's LANCET is well known to those medical men who are brought much in contact with the Lunacy Acts; but it does not admit of so ready a remedy as he seems to think, nor is the anomaly itself confined to Scotland, for the English Commissioners do not accept certificates signed by medical men practising in that country. An explanation of the reason for this will, perhaps, best show the difficulty of providing a remedy. The Lunacy Acts are expressly restricted in their operation to that part of the kingdom for which they were passed: thus, for instance, the "Lunatic Asylums Act, 1853," "shall extend only to England and Wales," and so on. A patient escaping from an English asylum cannot be retaken if he contrive to cross the Border, and a Chancery Lunatic cannot, I believe, be placed in a Scottish asylum. The placing of ordinary lunatics in English asylums on Scottish certificates, and *vice versâ*, would lead to endless confusion, as, for example, where the lunatic wished to see a medical man in another part of the kingdom for an alleged false certificate. The machinery by which patients are placed in an asylum, and that by which they are detained and discharged, differ in the two countries as much as it is possible for two systems aiming at the same object to do; and the Commissioners in Lunacy in England and in Scotland are quite right in the course which they have adopted. Nothing short of an amalgamation of the English and Scottish Lunacy Statutes would effect what Dr. Lockie desires, but such an amalgamation presents such very formidable difficulties that it may be called practically impossible, and so it is not necessary here to discuss its advantages and its drawbacks.

I am, Sir, your obedient servant,

April 15th, 1876. AN ENGLISH ASYLUM SUPERINTENDENT.

THE TREATMENT OF VARIOLA IN LYONS.

ON the 27th of March last the Medical Society of Lyons held a meeting, at which a report was read on the Prophylaxis of Variola. A discussion arose, and it is rather startling to find that hitherto small-pox patients had been admitted into the general wards. Nay more, a certain number of members objected to a special hospital for variolous patients—first, on the plea of expense; secondly, because the families of the afflicted would object to send them to be placed where none but variolous patients were admitted; and lastly, because such patients could not be prevented leaving the hospital half cured. All this falls to the ground when the highly contagious nature of the malady is taken into consideration, and the danger to which the community is exposed. During the whole discussion not a word was said of the Small-pox Hospital of London, which has effected so much good. It is to be hoped that at Lyons they will at least set apart wards for the reception of small-pox patients.

A. B. C. will feel much obliged if any gentleman will give him information about the prospects to be entertained by a young medical man beginning to practise at the Cape of Good Hope.

Leo.—The appointments are in the gift of the Local Government Board.

R. F. G.—Certainly so.

ERRATUM.—The specimen of Perforating Ulcer of the Stomach exhibited by Dr. Thorowgood at the meeting of the Pathological Society on April 4th was forwarded by Dr. Wilton (not Willis), of Sutton.

COMMUNICATIONS, LETTERS, &c., have been received from—Dr. G. Johnson, London; Professor Latham, Cambridge; Mr. J. Hutchinson, London; Dr. Murchison, London; Dr. Thorowgood, London; Mr. Callender, London; Dr. Sedgwick, London; Dr. Broadbent, London; Dr. Mapother, Dublin; Dr. M. Mackenzie, London; Mr. Fox, Exeter; Mr. Deschamps, London; Messrs. Barrand and Co., London; Mr. Sharman, Swinton; Dr. Wolfe, Glasgow; Mr. Sproule, Frome; Mr. Booth, Rochdale; Mr. Gardner, Higham Ferrers; Dr. Diamond, Muthill; Mr. Wadland, Hexham; Messrs. M'Kelvea and Sons, Greenock; Messrs. Wright and Co., London; Dr. Cuthertson, Zanesville; Messrs. Schacht and Co., Clifton; Mr. Hannan, Kurrachi; Mr. J. G. Brown, London; Mr. M'Gill, Leeds; Mr. M'Camack, Kennington; Mr. S. H. Cartwright, London; Dr. Flint, New York; Messrs. Pilgram and Lefevre, Chelsea; Mr. White, Masham; Mr. Hooper, Birmingham; Mr. Gibson, Halifax; Mr. Rose, Stornoway; Dr. Yeo, London; Mr. Cawthra, Bradford; Mr. Colton, Chichester; Mr. Castle, Newport; Mr. Parsons, Paris; Mr. Barry, Ramsgate; Dr. Edis, London; Mr. Hume, Sheffield; Mr. Arrowsmith, Darlington; Mr. Nestle, London; Dr. Nelson, Plymouth; Mr. Phillips, Tickhill; Dr. C. Black, London; Miss Towler, Canonbury; Mr. Moore, London; Mr. Gandie, Guisborough; Mr. W. Jones, London; Dr. Wharry, London; Mr. Chubbe, Lowestoft; Mr. Ingpen, London; Dr. Wilson, Worcester; Mr. Teevan, London; Mr. Graham, Loughborough; Mr. Waterson, Chester; Mr. Evans, Boughton; Mr. Marson, Cheltenham; Mr. S. Ward, Spalding; Mr. Steans, Olney; Mr. Roberts, Stratford-on-Avon; Mr. Casey, Belfast; Mr. Cayley, London; Mr. R. Valler, Chippenham; Mr. Lavenu, Maidstone; Mr. Oldacres, Burnley; Mr. Young, Peterborough; Dr. Payne, London; Mr. Walker; Mr. Major, Wakefield; Mr. Evans, Chepstow; Mr. Chapman; Dr. Cordwent, Taunton; Dr. R. W. Ellis, Manningtree; Mr. J. Woolston, Bristol; Mr. Perry, Douglas; Mr. Davids, High Beech; Dr. Ginders, Normanton; Mr. Hannay, Sheerness; Mr. Marshall, Ware; Mr. Stuart, London; Mr. Cutler, Woodford; Mr. Owen, Deal; Dr. Becke, Fort Wayne, Indiana, U.S.A.; Dr. Lakin, Leicester; Dr. Warren, Paris; Dr. Bodwin, Trenton, U.S.A.; Dr. Collyns, Wimbleton; Dr. Blyth, Barnstaple; Dr. Paulson, Mount Sorrel; Mr. Bennett; Registrar-General of Edinburgh; An Indian Surgeon; A Blockhead; Simon Petras; R. F. G.; An Unqualified Assistant; Alpha, Nottingham; A. B. C.; Fiat Justitia; Cantab.; F.R.C.P.; Argus; An English Asylum Superintendent; W. S.; W. R. H.; Enquirer; Epsilon; Omicron; The Royal Academy of Arts; Chirurgus; Cantabriensis; Fair Play; M.R.C.S., Mold; G. W.; &c. &c.

LETTERS, *each with enclosure*, are also acknowledged from — Mr. Beales, Congleton; Dr. Heron, King's Cliffe; Mr. Vernon, Great Broadfield; Messrs. Bradshaw, Nottingham; Mr. Macaskie, Berwick; Dr. Waters, Liverpool; Messrs. Wotherspoon, Paisley; Mr. Lowis, Bath; Mr. Walker, Corwen; Dr. Chalmers, Bannockburn; Mr. Howard, Abergavenny; Mr. Whiffen, Battersea; Mr. Jarman, Huddersfield; Dr. Great Rex, Lawton; Mr. Wolverson, Alfreton; Messrs. Smith and Son, Dublin; Messrs. Cole and Son, Liverpool; Dr. Row, Devonport; Mr. James, Cwm Avon; Mr. Lawrence, Tunbridge Wells; Mr. Eberle, Easingwold; Dr. Fawcett, Taunton; Dr. Harding, Whittlesea; Mr. Thomas, Narberth; Mr. Lamb, Albrighton; A. B., Fort William; Sarcoma, Manchester; Medicus, Mottram; M. S., Dalston; G. P. O., Ballindalloch; M. A., Darlington; A. B., Holborn; B. B., Preston; Medicus, Baslow; Alpha, Conway; Junius, Edinburgh; Tempus, London; B. X., Dorchester; M.D., London; Medicus, Coventry; A. L., London; D. W. W.; M. K., Liverpool; B. A., Wotton; G. H., Wigan; Delta, Newcastle-on-Tyne; W. R. P., Glasgow; Beta, Wigan; W. E. B., Sanningdale; G., Norwich; Omega, Stroud; Medicus, Willenhall; B., Plymouth; A. C., Bruton; Medicus, Bangor; A. C. P., Huddersfield; Physician; Z., Broadstairs; J. A. G.; L. L. B., Haxton; H. S.; C. D., Huddersfield.

Solicitors' Journal, Liverpool Daily Post, Welshman, Examiner, Colonies, Pharmaceutical Journal, Cork Constitution, Birmingham Morning News, Glasgow Herald, Metropolitan, Surrey Advertiser, East London Observer, Bombay Gazette, Newcastle Daily Chronicle, and *South London Observer* have been received.

METEOROLOGICAL READINGS

(Taken daily at 8 A.M. by Steward's Instruments.)

THE LANCET OFFICE, APRIL 20TH, 1876.

Date.	Barometer reduced to Sea Level and 32° F.	Direction of Wind.	Wet Bulb.	Dry Bulb	Solar Radia in Vacuo	Max. Temp. Shade	Min. Temp.	Rainfall.	Remarks at 8 A.M.
April 14	29·89	E.	38	36	...	48	32	0·32	Overcast
„ 15	30·28	E.	42	46	...	56	36	...	Fine
„ 16	30·12	E.	44	53	...	54	37	...	Cloudy
„ 17	29·99	S.W.	44	45	...	50	38	...	Overcast
„ 18	29·26	S.	46	49	...	57	39	...	Overcast
„ 19	28·93	S.	40	43	...	53	44	0·08	Cloudy
„ 20	29·29	S.W.	47	51	...	58	45	0·12	Fine

Medical Diary for the ensuing Week.

Monday, April 24.

ROYAL LONDON OPHTHALMIC HOSPITAL, MOORFIELDS.—Operations, 10½ A.M. each day, and at the same hour.
ROYAL WESTMINSTER OPHTHALMIC HOSPITAL.—Operations, 1½ P.M. each day, and at the same hour.
ST. MARK'S HOSPITAL.—Operations, 9 A.M. and 2 P.M.
METROPOLITAN FREE HOSPITAL.—Operations, 2 P.M.
MEDICAL SOCIETY OF LONDON.—8½ P.M. Dr. Semple, "On the Pathology and Treatment of Cerebral Diseases." — Dr. Wiltshire, "On a New Operation for Rupture of the Perineum."—Mr. W. B. Hemming, "On a Case of unusual Obstruction of the Bowels from Gall-stones."

Tuesday, April 25.

GUY'S HOSPITAL.—Operations, 1½ P.M., and on Friday at the same hour.
WESTMINSTER HOSPITAL.—Operations, 2 P.M.
NATIONAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
WEST LONDON HOSPITAL.—Operations, 3 P.M.
ROYAL MEDICAL AND CHIRURGICAL SOCIETY.—8½ P.M. Mr. H. Morris, "On a Case of Intermitting Hydronephrosis, with Remarks on Hydronephrosis as a Cause of Abdominal Tumours." — Mr. Donald Napier will exhibit a New Method of Producing Local Anæsthesia.

Wednesday, April 26.

MIDDLESEX HOSPITAL.—Operations, 1 P.M.
ST. MARY'S HOSPITAL.—Operations, 1½ P.M.
ST. BARTHOLOMEW'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
ST. THOMAS'S HOSPITAL.—Operations, 1½ P.M., and on Saturday at the same hour.
KING'S COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at 1½ P.M.
GREAT NORTHERN HOSPITAL.—Operations, 2 P.M.
UNIVERSITY COLLEGE HOSPITAL.—Operations, 2 P.M., and on Saturday at the same hour.
LONDON HOSPITAL.—Operations, 2 P.M.
SAMARITAN FREE HOSPITAL FOR WOMEN AND CHILDREN.—Operations, 2½ P.M.
HUNTERIAN SOCIETY.—8 P.M. Mr. Rivington, "On a Case of Partial Rupture of the Popliteal Artery and Complete Rupture of the Popliteal Vein, treated successfully by Primary Amputation of the Thigh."—Mr. Corner, "On a Case of Transfusion for Collapse."

Thursday, April 27.

ST. GEORGE'S HOSPITAL.—Operations, 1 P.M.
ROYAL ORTHOPÆDIC HOSPITAL.—Operations, 2 P.M.
CENTRAL LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M., and on Friday at the same hour.

Friday, April 28.

ST. GEORGE'S HOSPITAL.—Ophthalmic Operations, 1½ P.M.
ROYAL SOUTH LONDON OPHTHALMIC HOSPITAL.—Operations, 2 P.M.
CLINICAL SOCIETY OF LONDON.—8½ P.M. Mr. Spencer Watson, "On two Cases of Glaucoma treated by Subconjunctival Sclerctomy" (the Patients will be exhibited).—Dr. Buzzard: "A Railway Case: Cerebro-spinal Concussion with Glycosuria." — Dr. Greenhow: "A Case of Patent Ductus Arteriosus, attended by a Thrill and Murmur; Death from Phthisis."

Saturday, April 29.

ROYAL FREE HOSPITAL.—Operations, 2 P.M.
CHARING-CROSS HOSPITAL.—Operations, 2 P.M.

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